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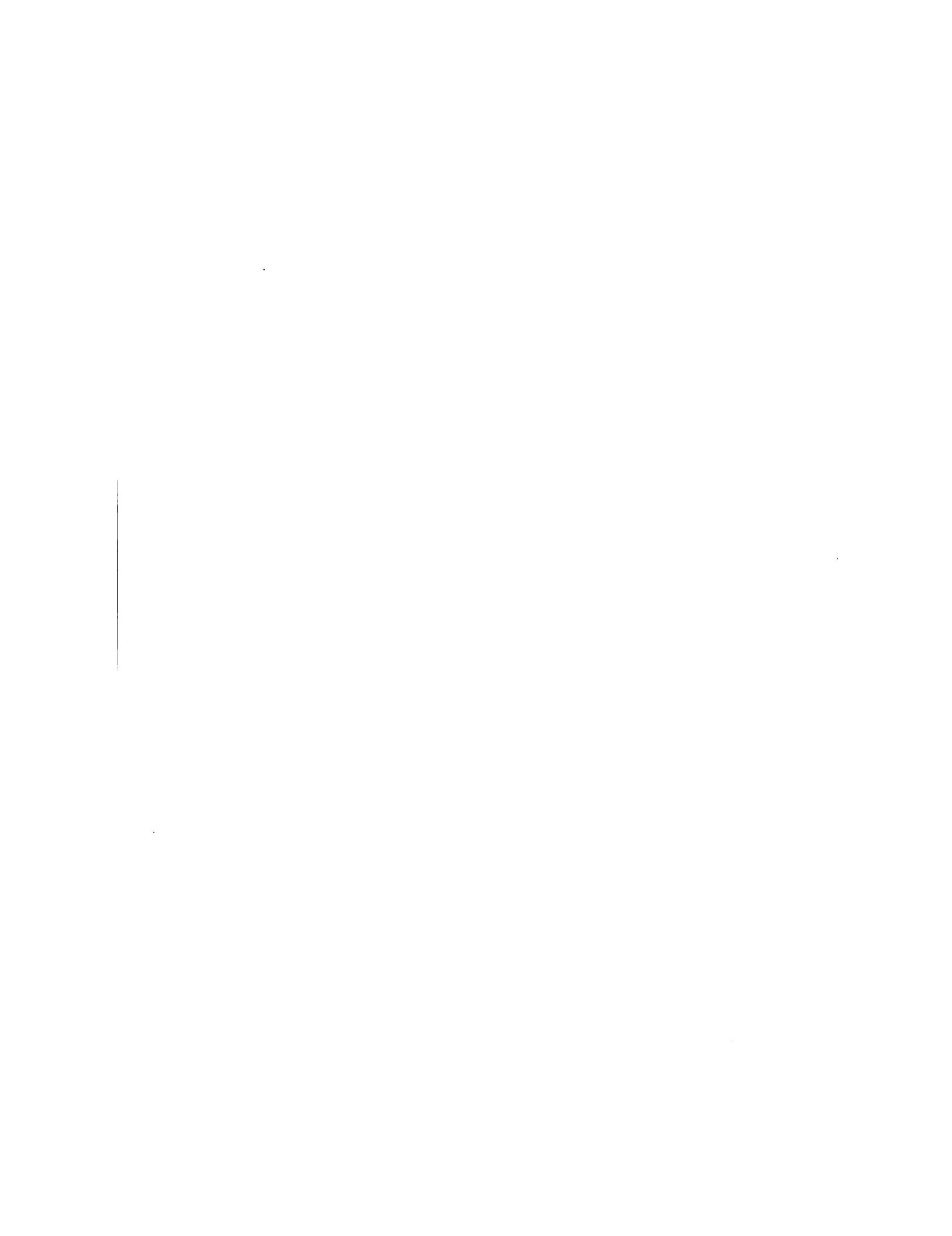
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PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ONE HUNDREDTH ORDINARY MEETING, November 3, 1905.

CHARLES J. SYMONDS, F.R.C.S., President, in the Chair.

PHILIP R. W. DE SANTI, F.R.C.S. }
HENRY J. DAVIS, M.B., M.R.C.P. } Secretaries.

Present—34 members and 2 visitors.

The minutes of the preceding meeting were read and confirmed.

ELECTION OF HONORARY MEMBER.

The ballot was taken for—

ERNEST PLAYFAIR, M.B.Lond., M.R.C.P., London,
who was elected a Member of the Society.

NOMINATION OF ORDINARY MEMBERS.

F. A. ROSE, M.B., B.C.Cantab. F.R.C.S., London,
B. C. GHOSH, B.A.Cantab., L.S.A., Calcutta,
T. G. OUSTON, F.R.C.S., Newcastle-on-Tyne,

were nominated for election at the next meeting.

The following cases and specimens were shown :

CASE FOR DIAGNOSIS, PROBABLY MALIGNANT DISEASE OF THE MAXILLARY ANTRUM.

Shown by Dr. DUNDAS GRANT. The patient, a woman, aged forty-four, was referred to Dr. Grant for a swelling just below the left orbit, which appeared rather rapidly and had existed for three weeks; it was moderately firm, the skin over it was slightly thickened, the alveolar border was quite free, and no egg-shell

crackling was perceived on palpation. There was little or no pain on pressure, and there was numbness of the left half of the upper lip; there was a polypoid growth in the left middle meatus of the nose, which, when removed, was found to be somewhat papillated on the surface. The antrum was completely opaque on transillumination. Pending examination of the growth, no further exploration was carried out. In regard to the possibility of the swelling being gummatous, inquiry was made as to the family history, which was as follows: The first and second children still alive, the third still-born, the fourth died at three and a half years, there was then a miscarriage, and afterwards a boy, still living, then another miscarriage, and lastly a boy, now six years old, strong and healthy. Iodide of potassium, in 5-grain doses, was administered, and the following week it was increased to 10 grains, with the addition of $\frac{1}{2}$ drachm of the solution of perchloride of mercury. The microscopical examination made by Mr. Wingrave showed the structure to be that of a fimbriated papilloma, but with changes in the nuclei suggestive of the gamitoid arrangement found in a malignant disease. The patient had subjectively improved, but the swelling had not diminished. On puncturing the antrum from the inferior meatus by Lichtwitz's method, the trocar traversed the bone with abnormal ease and appeared to enter a large free cavity. When air was insufflated bubbles issued from the middle meatus, and a lotion driven through emerged freely, being merely blood-stained, with no admixture of pus. An exploring needle was introduced between the cheek and gum into the swelling; no blood or pus was withdrawn, and the point of the needle touched rough, bare bone. The question then arose as to whether the swelling, as at first seemed probable, was the protrusion of a malignant growth through a rapidly dehiscent maxillary bone, or, as now seemed possible, a gummatous periostitis. There was no morbid appearance in the naso-pharynx and no bulging of the floor of the antrum into the mouth or nose. The nature of the growth examined by the microscope seemed somewhat indefinite. Dr. Wyatt Wingrave had prepared sections, and with them sections of a nasal outgrowth in a case which appeared to be epithelioma of the antrum, in which a surgical friend removed the superior maxilla totally, and where recurrence has not taken place, the patient, a man, aged sixty-three, being present to-day for inspection.

The PRESIDENT said that from the situation, the raising of the orbital floor, and the obliteration of the orbital margin of the bone, he thought it a sarcoma and of rapid growth, and one demanding immediate operation,

The absence of nasal destruction and of depression of the palatal roof pointed to a limitation of the disease to the orbital portion of the bone. He advised free removal by the upper and orbital portion, leaving the palate.

Dr. PEGLER proposed that these interesting sections should be referred to the Morbid Growth Committee for discussion. Dr. Wingrave, who had left the meeting, expressed a wish (to the speaker) to the same effect.

Dr. SCANES SPICER said that the diagnosis might be cleared up, by making a large opening in the anterior wall (as in the radical antral empyema operation) and examining the contents with the naked eye and histologically. He thought this should be done, and if malignant, excision of the upper jaw and affected tissues could be therefore carried out.

CASE OF A PEDUNCULATED TUMOUR, PROBABLY CYSTIC, GROWING FROM THE SUPRA-TONSILLAR FOSSA.

Shown by Dr. DUNDAS GRANT. The patient was a woman, aged sixty-eight, and the growth had probably existed for a very long time, but was only observed by the patient one month before Dr. Grant saw her, her attention having apparently been drawn to it by difficulty in swallowing owing to a temporary pharyngitis.

Dr. JOBSON HORNE considered, from his experience of similar tumours, that under the microscope the pedunculated excrecence would be found to consist mainly of tonsillar tissue with, perhaps, cystic degeneration towards the centre.

CASE OF TRAUMATIC LESION OF LARYNX.

Shown by Dr. DUNDAS GRANT. The patient was a lady, aged twenty-three, her sole complaint when brought to Dr. Grant on October 27 being loss of voice with attacks of suffocation. There were several scars across the neighbourhood of the larynx, extending upwards and backwards on the left side, the result of attempts of self-destruction by cutting the throat on May 31 last.

Most of the cuts, according to the report of the surgeon who attended her at the time, were quite shallow, with the exception of one which penetrated the larynx through the thyroid cartilage. There was considerable infiltration of the left half of the larynx, and a reddish band in the form of a web ran obliquely from right to left and from behind forwards, covering a large portion of the right vocal cord and a small portion of the left. The cords did not approximate sufficiently for the production of voice, but the obstruction was not sufficient to interfere with breathing; in fact, it seemed unquestionable that the attacks of stridor were purely hysterical;

there was a slight fulness of the thyroid body. A marked feature on the exterior of the larynx was a ridge running obliquely upwards and backwards on the left half of the larynx and which seemed to be the dislocated posterior portion of the thyroid cartilage. Suggestions as to treatment, operative or otherwise, were requested, but it seemed doubtful whether anything would improve the voice except the gradual acquisition of ventricular band phonation, and there seemed no reason to interfere for the sake of inspiratory trouble.

CASE OF DIVERTICULUM OF THE OESOPHAGUS.

Shown by Dr. DUNDAS GRANT. The patient was a woman, aged fifty-one, exhibited on May 5; the members might remember the skiagram, showing the diverticulum full of bismuth. Dr. Grant removed the diverticulum by external operation on May 30, and for several days a tube was left in the oesophagus, passing through the nose; the patient bore it without complaint, and when it was removed she was able to swallow without difficulty. She swallowed now easier than before the operation, enjoyed her food, and had gained in weight.

IMMOBILE LEFT CORD IN A LAD AGED SEVENTEEN.

Shown by Dr. KELSON. A weakness and peculiar tone of voice had been noticed for about five years, and for the same period food and liquids regurgitated through the nose. These symptoms did not appear to follow any particular illness. On examination the left side of the palate was found to be immobile and also the left vocal cord. The knee-jerks were somewhat free, but there did not appear to be any weakness, tremor, or rigidity about the muscles of the limbs or neck.

Dr. DE HAVILLAND HALL said that he had been struck by the number of cases of immobile left vocal cord which had been brought before the Society without any definite explanation as to the cause. He was of opinion that, just as in facial paralysis, some of these cases were due to neuritis, and he mentioned a case of the kind in which complete recovery had followed the use of iodide of potassium and strychnine and the administration of electricity.

Dr. DUNDAS GRANT thought the cause of the paralysis was high up, probably in the vago-accessory nucleus, but certainly above the origin of the pharyngeal branch, as shown by the paralysis of the corresponding half of the soft palate. He detected marked nystagmus when the eyes were turned to the side; the knee-jerks were exaggerated, and the patient

stated that he had some trouble in effecting micturition, not apparently from any mechanical obstruction. He recommended complete examination of the patient from the neurological point of view, especially with regard to the possibility of the case being one of multiple sclerosis, of which, however, he would not presume to make a definite diagnosis.

Mr. BARWELL said there was distinct paresis of the left side of the palate and marked nystagmus, especially at the extremes of conjugate deviation to right and left. This pointed to a central rather than a peripheral cause; the fact that the nystagmus occurred on fixation might bear out Dr. Dundas Grant's suggestion of disseminated sclerosis.

Sir FELIX SEMON said that the combination of paralysis of the left half of the palate and of ocular nystagmus with the laryngeal paralysis definitely showed that the cause of the immobility of the left vocal cord in this case could not be due to a peripheral neuritis, but to a lesion higher up, in which the internal branch of the spinal accessory as well as the fibres coming from the nucleus ambiguus were concerned. Further than this he would not go after the one examination he had been able to make, and he certainly saw no cause for assuming that the lesion was of the nature of a multiple sclerosis. Seeing the long duration of the disease in this case, almost certainly other more characteristic symptoms would have developed if multiple sclerosis were indeed at the root of the patient's trouble. Large experience had taught him to be very reserved in committing himself to a definite diagnosis in this class of cases. Often enough these paralyses existed for many years without leading to any further development.

Dr. FITZGERALD POWELL said the case was a very interesting one. The paralysis of the cord was accompanied by paralysis of half the soft palate and nystagmus. He did not see any symptoms of disseminated sclerosis, and was of opinion that in all probability the case was a peripheral neuritis, the result of some toxin such as diphtheria or influenza. He had shown a case at a previous meeting of paralysis of one vocal cord caused by the poison of influenza.

Dr. KELSON, in reply, said that the fact that there was evidence of paralysis of the cord and palate having lasted five years was very much against it being a diphtheritic paralysis.

CASE OF ABNORMALLY LARGE EUSTACHIAN CARTILAGES PROJECTING
INTO THE NASO-PHARYNX TO THE EXTENT OF INTERFERING WITH
FREE NASAL BREATHING, IN A GIRL AGED SIXTEEN.

Shown by Dr. FURNISS POTTER. The patient first came under observation owing to a feeling of stuffiness in the nose. On examining the naso-pharynx, two large red swellings were seen projecting from the sides of the cavity, obstructing to a considerable extent the view of the choanae. At the first glance they gave the impression of being enlarged posterior extremities of the inferior turbinals, but closer inspection showed that the latter could be partially seen beyond. The contour of the swellings, the orifices of the Eustachian tubes, and the well-marked Rosenmüller's fossæ justified the presumption of regarding them as

abnormally large cartilaginous extremities of the Eustachian tubes. The exhibitor was of opinion that the enlargement was not due to a pathological cause, although the patient was the subject of double chronic otorrhœa, and muco-pus could be seen adhering to the mucosæ of the naso-pharynx.

In his (Dr. Potter's) experience the condition was unique.

Dr. DONELAN said he had reason to think this condition caused obstructed breathing and other symptoms suggestive of adenoids oftener than was generally supposed. He had begun to collect cases of its occurrence, and had notes of six during the past two or three years. In the last case, about a fortnight ago, a boy, aged five, was brought to the Italian Hospital to have his adenoids removed, and on examining him under chloroform, the immensely enlarged Eustachian cartilages and pterygoid plates reduced the width of the naso-pharynx to under half an inch. It was somewhat remarkable that neither in this nor in any of the other cases were any adenoids present.

Dr. WILLIAM HILL said that his experience did not lead him to think that enlargements of the Eustachian cushion of sufficient size to cause respiratory obstruction were at all common; but he had met with one case, a youth of fifteen or sixteen, in which the cartilages were not only enormously enlarged, but were so hard to digital examination as to suggest that they might have undergone ossification. The obstruction in the naso-pharynx was so great that the patient was supposed to be suffering from adenoids. In the case of Dr. Potter, he (the speaker) had made a digital examination, and had come to the conclusion that much of the enlargement on the right side was due to great infiltration of the soft tissues of the salpingo-pharyngeal and palatal folds. The condition was analogous to that met with in pharyngitis hypertrophica lateralis; and like that condition, the present lesion appeared to be associated with the presence of irritating matter in the naso-pharynx, which possibly came from some of the posterior sinuses. He regarded the condition as inflammatory rather than due to any malformation of the Eustachian orifice.

Dr. FITZGERALD POWELL thought that a very narrow post-nasal space was a factor in intensifying the appearances of the enlarged Eustachian cushion, the pterygoid plates being inclined more towards the middle line than usual. It certainly appeared to him that the post-nasal space was contracted.

The PRESIDENT said he had been examining the post-nasal space for a good many years, and had not seen so marked a condition before. There was a good deal of mucus adherent to the pharyngeal wall and round the Eustachian orifices, which somewhat obscured the view. He suggested that after this had been attended to it would be interesting to show the case again.

Dr. PEGLER attributed the stagnation of muco-pus in the naso-pharynx to an inflammatory condition of the lymphoid tissue, which he thought contributed a good deal to the general thickening of the naso-pharyngeal structures.

Dr. FURNISS POTTER, in reply to Dr. Hill, said that he also had just examined the swellings digitally, and that they felt firm and hard, giving the impression of cartilage covered by mucous membrane. Out of the thousands of cases one saw with otorrhœa and pus in the naso-pharynx, he could not imagine that this could be the cause of such a very unusual

condition. He could not agree with Dr. Fitzgerald Powell as to the size of the post-nasal space: he thought it was of average capacity, the narrowness being only apparent owing to the projections. He also thought that these cases could hardly be quite so frequently met with as Dr. Donelan's remarks would lead one to suppose.

MAN WITH MALIGNANT DISEASE OF THE BASE OF THE TONGUE AND EPIGLOTTIS: QUESTION OF OPERATION.

Shown by Mr. DE SANTI. The patient, aged fifty-six, had been troubled with pain and salivation for over six months, but only recently came to hospital for advice. There was a large epitheliomatous ulcer at the base of the tongue, extending to and involving extensively the epiglottis and larynx and also the pharynx. The glands on both sides of the neck were involved, and formed masses under both sterno-mastoid muscles. The patient had been losing flesh rapidly; his mother died of carcinoma. The patient was brought forward only as to the question of operation. In Mr. de Santi's opinion the disease was of so extensive a nature that he considered it could not with safety be entirely eradicated by operation. Any operation undertaken would necessitate removal of the whole tongue, the upper part of the larynx, part of the pharynx, and all the glands on both sides of the neck. Even so, and if recovery from so extensive an operation followed, it would be impossible to define the limits of the glandular involvement, and rapid recurrence was certain.

Sir FELIX SEMON said that Mr. de Santi had asked what course the surgeon was to follow in such sad cases as the one shown. This was indeed a most difficult and responsible question. He had by chance had the opportunity of seeing no less than three almost identical cases of this kind within the last three weeks, and he always felt his responsibility most keenly in advising in cases of this category. The best solution, he thought, of the difficulty, was to lay the two alternatives clearly but kindly before the patient and his friends, and leave the decision to them. Doing nothing meant, of course, a certain and very distressing death within a comparatively short time. Operation, on the other hand, meant a very serious operation, which very possibly could not be completed, and which exposed the patient to the risk of death from the operation itself, whilst no promise could be given with regard to recurrence. Still, it was the patient's *only* chance, and personally he must say that he would rather die from the operation itself than the lingering death if matters were left alone. In practice it would be found that after such an explanation patients would decide differently according to their temperaments. In the present case the chances were certainly very unfavourable, owing to the involvement of the lateral wall of the pharynx and the number of glands affected.

Dr. FUNNIS POTTER said that this case had a special interest for him.

as during the last few days he had had under his observation an almost parallel case, and had only yesterday witnessed an extensive operation for the removal of the disease. This patient had the pros and cons put clearly before him almost exactly as Sir Felix Semon had just indicated, and he had decided to undergo operation. When the operator had laid clearly open to view the field of disease, he was much gratified to find that he would be able to get well outside the growth, and so insure removing the whole of it. He removed the base of the tongue with the epiglottis and part of the lateral wall of the pharynx. In Mr. de Santi's case he thought the prospects of complete removal were not so good as in the one he had just referred to, as the disease appeared to be much more extensive, involving the larynx and also the lateral walls of the pharynx to a considerable extent.

Dr. LAMBERT LACK said that these cases might sometimes be subjected to operation with a reasonable hope of success. He thought Mr. de Santi's patient might be operated on, although the disease in the throat was very extensive, and he was not prepared to say from the examination he has made, if it could all be removed. The case he had shown on a previous occasion at the Society with disease in the same region, and with extensive glandular involvement of both sides of the neck, was still alive and well, two and a half years after the operation.

Dr. SCANES SPICER referred to a case of extensive extirpation of parts for malignant disease of larynx, pharynx, and oesophagus, in which there was glandular enlargement on both sides. In conjunction with two colleagues—general surgeons—an attempt was made to extirpate the disease at one operation as described by Professor Glück. The patient's general condition did not permit of the gland removal, after the larynx, etc., had been removed, and the patient collapsed from heart failure some hours afterwards. In talking over this case later with Professor Glück, the latter said that in this case he would have removed the glands first, thus lessening the duration and shock of the main operation. This consideration might likewise apply to Mr. de Santi's case.

The PRESIDENT said he doubted if it were surgically possible to make a complete removal in this case. The larynx, with much of the pharynx and part of the tongue, would require removal, and he thought the glandular infection had got beyond the limits of complete extirpation.

Mr. DE SANTI, in reply, said he was obliged to members for their opinions. As he had already said, he did not consider the whole of the disease could be removed. He remembered Dr. Lack's case quite well, and though a brilliant result followed from operation, yet Dr. Lack's case was by no means of such an extensive nature as the case now shown. He would put the whole matter clearly before the patient and leave it to him to decide.

(Subsequently to the meeting the patient decided to have no operation done.)

WOMAN WITH PERVERTED ACTION OF THE CORDS, SHOWN AT A PREVIOUS MEETING.

Shown by Mr. DE SANTI. This woman had continued under Mr. de Santi's care as an out-patient since the June meeting. Despite all forms of ordinary treatment she had got worse, and

when seen again in September, after the holidays, was found to be suffering acutely from inspiratory dyspnœa and general cyanosis. She was accordingly admitted under Dr. de Havilland Hall, Mr. de Santi's colleague at the hospital. From Dr. Hall's observation of the patient in the hospital he concluded that there was probably more than perverted action of the cords, and some real obstruction, possibly from the enlarged isthmus of the thyroid. He asked Mr. de Santi to perform tracheotomy. After the patient had taken a few whiffs of chloroform her breathing became quite normal; a little later she became talkative, and spoke with quite a natural voice. Mr. de Santi therefore concluded the patient had no real obstruction at all, and decided not to perform tracheotomy. The isthmus of the thyroid being very enlarged, Mr. de Santi decided to excise a piece from the centre, and this was done partly to cause reduction of the enlarged lobes of the thyroid and partly for moral effect. The nurse was instructed to tell the patient on her recovery from the anaesthetic that all obstruction had been removed. The immediate result was normal breathing and speaking voice.

Dr. DE HAVILLAND HALL said that on admission into his ward the patient was cyanosed, and the breathing was so persistently of a stridulous nature that he thought there must be some direct pressure on the trachea. He was of opinion that Mr. de Santi was completely justified in the operation he had undertaken.

Dr. SCANES SPICER said that if Mr. de Santi's operation had here removed perverted action of the cords, it rather suggested the possibility of some local pressure on the laryngeal nerve supply as a cause of the puzzling perversion.

Dr. JOBSON HOENE said that in the event of a recurrence of the symptoms complained of, it would be interesting to know the effects of an administration of a general anaesthetic without the performance of an operation.

MAN, AGED EIGHTY, WITH SARCOMATOUS GROWTH OF LEFT NASAL CAVITY; QUESTION OF OPERATION.

Shown by Mr. DE SANTI. The patient had been under observation about six weeks. The left nasal cavity was filled with a soft, dark, vascular growth, polypoidal in shape, and attached, as far as could be ascertained, to the septum nasi. Pieces had been removed on three occasions, and subjected to microscopic examination by Dr. Hebb. On each occasion the report was sarcoma.

There was no opacity of the left antrum of Highmore. The question of interest was whether, bearing in mind the age and general weakness of the patient, any large outside operation was justifiable.

Dr. DUNDAS GRANT thought the growth might be completely removed with the portion of the septum on which it grew with every chance of non-recurrence. He considered the morbid histology of tumours of the septum was most peculiar, and that even when they presented features of malignancy under the microscope they were eradicable without necessary recurrence.

Dr. PEGLER remarked upon the rarity of these cases of septal sarcoma. He believed he was correct in stating that this was the first patient shown to the Society of sarcoma confined to the septum. Dr. J. W. Bond's interesting case, twice shown, last time exactly nine years ago, was attached to the septum, floor, and outer wall of the fossa. Dr. Barclay Baron showed a doubtful case of nasal sarcoma two years later. In a case of his own a great many years ago, in an old man, after removal with the snare, followed by free haemorrhage, the growth rapidly recurred, and the patient did not live long afterwards. He was sure the Society would support him in urging Mr. de Santi to place them in possession of this specimen after the next removal for examination.

A CASE OF TUMOUR IN THE INTERARYTENOID FOLD, PROBABLY TUBERCULOUS, IN A MAN, AGED ABOUT FORTY.

Shown by Sir FELIX SEMON. The patient, a gentleman, aged forty, was sent to Sir Felix Semon by Dr. Crawford Watson, of Harrogate. Thirteen years ago he broke down with pulmonary trouble, went to South Africa, and lived there until a year ago, when he returned home. There was still harsh breathing posteriorly in the upper part of the left lung; there were a few tubercle bacilli in the sputum, but very little expectoration, and the patient was well in all other respects. Lately his voice became a little husky, and Dr. Watson discovered a swelling in the posterior part of the larynx, closely adjoining the posterior end of the right vocal cord. He wished Sir Felix Semon's opinion as to its nature, and as to the question whether the growth should be removed in view of possible tuberculous infection of the larynx from auto-inoculation from the wound thus caused.

On examination the exhibitor found a large longitudinal out-growth of moderate hardness on the right side of the interarytenoid fold closely adjoining, but not connected with, the posterior end of the right vocal cord. The tumour was covered by normal mucous membrane. In all probability the growth was of the nature of a tuberculoma, although different in aspect to the tuberculous infiltration so frequently seen in the interarytenoid fold. As the tumefaction caused very little inconvenience, and as Sir Felix shared Dr. Watson's apprehensions with regard to infection from the wound, he recommended leaving it alone for the present and being guided as to whether it should be removed at all by the

further progress of the case, but he wished to give the opportunity to the Society of seeing the rather uncommon condition of things.

Dr. DUNDAS GRANT thought this tumour was comparable to *verruca necrologica* which developed in those who made *post-mortem* examinations and which were usually slow tubercular growths; he thought the galvano-cautery might be applied, care being taken not to cauterise the adjacent portions of the interarytenoid space for fear of causing such cicatricial contraction as to prevent the arytenoid cartilages from diverging during inspiration.

Dr. DE HAVILLAND HALL said that he would not have made the diagnosis of the growth as being tuberculous in nature. He had never seen so isolated a growth in tuberculous disease of the larynx. To him it looked more like a fibroma than a tuberculoma. It was quite clear that operative interference was not advisable.

CHRONIC THICKENING AND DEFORMITY OF EPIGLOTTIS AND VOCAL CORDS OF FOUR YEARS' DURATION IN A GIRL AGED SIXTEEN; FOR DIAGNOSIS.

Shown by Dr. DONELAN.

Mr. DENNIS VINRACE remarked that, with regard to the suggestion that the patient was the subject of either hereditary or acquired syphilis, her comely appearance and general physical condition and the absence of signs were not in harmony with the victim of syphilis throughout life. If the laryngeal ulceration were due to syphilis, it was of the acquired variety.

Mr. BARWELL said that the nodular infiltration of the epiglottis, the type of patient affected—in fact, the entire aspect of the case—was typical of lupus of the larynx.

Dr. PEGLEE had also come to the conclusion that this was a case of lupus, for which the best treatment would be constitutional by a course of arsenic.

Dr. WATSON WILLIAMS said that in view of the probability of this being a case of lupus, he suggested the desirability of trying the administration of tuberculin in repeated small doses, just sufficient to produce slight reaction, and continuing it for some time, as he had found gratifying results from the use of this remedy, which in his opinion might with advantage be resorted to more frequently, especially in such cases as this, where, from the deposit being none too limited, surgical procedure would be somewhat extensive before complete eradication could be anticipated.

Dr. DONELAN, in reply, said that while there were no grounds whatever to think there was any acquired syphilis, as the patient was taking a mixed antisyphilitic treatment in view of a possible congenital faint when he first saw her, he had continued that treatment for a time, especially as there was a considerable diminution in the size of the proliferations, with consequent improvement in voice. He discontinued it, however, in July, when the patient went to France. On her return lately he looked on the case as one of lupus, and commenced treatment by arsenic, but had not yet had an opportunity of pushing the dose. He would use tuberculin if the arsenic did not produce a good result.

A POINT IN THE DIFFERENTIAL DIAGNOSIS OF EXCRESENCES IN THE
INTERARYTENOID SPACE.

Dr. JOBSON HORNE exhibited a series of photographs of macroscopic and microscopic preparations to illustrate a means of discriminating tuberculous excrescences in the interarytenoid space from those of a non-tuberculous nature. Dr. Horne said the excrescences in the interarytenoid space, with which more commonly they were concerned, were of one kind, but occasioned by different agents, and the diagnosis which they were more usually called upon to decide was whether the excrescences were of a tuberculous, simple, or syphilitic nature, and of these the most common were the tuberculous and the simple variety. Both were brought about by pachydermatous changes in the epithelium—that was to say, the epithelium underwent a hyperplasia and a metaplasia. The point to which Dr. Horne wished to draw attention was that in the simple variety (*pachydermia verrucosa simplex*) the excrescence was an exaggeration of pre-existing parts, so that the natural central furrow in the interarytenoid region was maintained in the growth, which was a symmetrical one, occupying the centre of the interarytenoid space. In the tuberculous variety (*pachydermia verrucosa tuberculosa*) the growth did not occupy a central position; it was usually developed more on one side of the space, and the central furrow was lost.

MULTIPLE PAPILLOMA OF THE LARYNX IN A MAN OF FORTY-ONE, WHICH
HAD REURRED AFTER THREE YEARS' TREATMENT ENDING FIFTEEN
YEARS AGO.

Dr. SCANES SPICER showed this case of ulcerating warty masses covering the whole interior of the larynx and the under-surface of the epiglottis. The nature was unequivocal fifteen years ago, simple papilloma, with no evidence of tubercle, or malignancy, or syphilis. Now, these possibilities might again demand consideration. The histological examination of parts removed this week again showed papilloma, but his study of the case was as yet not completed. He was doubtful whether, owing to the extremely diffused character of the mass and the readiness with which it bled and interfered with operative removal, the poor general state of the patient's health, and the importance of the time factor, it would not be better to perform laryngo-fissure and remove the diseased tissue. This was totally opposed to his general principle and

practice in papilloma, but if ever such a course was justified, this case appeared to be a suitable one for the procedure.

[In conversation on the case, after examining the larynx, Dr. STCLAIR THOMSON regarded it as tubercular, because the growth and ulceration had extended to the epiglottis. Sir FELIX SEMON thought it would be better to attack it through the mouth after combined chloroform and cocaine anaesthesia.]

Dr. DUNDAS GRANT thought there was great suspicion of the disease being really tubercular, and that before the performance of any operation, such as thyrotomy, this diagnosis ought to be carefully considered and, if possible, excluded.

Dr. WATSON WILLIAMS said that he could not help feeling that the appearances presented were very suggestive of laryngeal tuberculosis, the more especially as there was considerable swelling and infiltration in the arytenoid regions. He thought, too, that the appearance of the patient and the fact that the pulse-rate was over 100 pointed in this direction. While, of course, all felt difficulties in diagnosis of such cases, and it was quite possible the appearances were to some extent modified by the recent local treatment, the existence of tuberculous disease should be excluded before operative measures were resorted to.

Dr. FITZGERALD POWELL thought that the first thing to be done was to make the diagnosis certain and exclude the possibility of tuberculous laryngitis by the examination of the sputum, etc. At the same time, no time should be lost in clearing the man's larynx of the growth and giving him breathing space. This could be easily done through the mouth with Mackenzie's forceps. He would strongly oppose opening the larynx. He had had considerable experience in these cases, and had found that the growths could be well kept down and eventually stopped growing by the interlaryngeal method. The removal of these growths by thyrotomy was no more efficacious in preventing their recurrence than the other method, and was more likely to injure the voice.

Dr. JOBSON HORNE said it was difficult to lay down any hard and fast rule for the treatment of papillomata in the larynx. One had to take into consideration the age of the patient and the amount of the dyspnoea. Dr. Horne cited the case of a child, aged eighteen months, in whom tracheotomy had to be performed for the relief of dyspnoea prior to the case coming under his care. The larynx was found to be packed with papillomata. In order to get rid of the tracheotomy tube there was no alternative course to performing a laryngo-fissure for the removal of the growths. This he had done, and the child was now able to breathe *per vias naturales*.

A CASE OF SUBACUTE OSTEOMYELITIS OF FRONTAL BONE, WITH EMPYEMA OF RIGHT FRONTAL SINUS, SHOWN ON MAY 5, 1905.

Dr. SCANES SPICER showed this patient again, as he had recently presented himself with a great increase of the bulging projection of bone into the orbit and also round the trephine hole over the brow. There had been considerable headache, and every two or

three days a small muco-purulent scab from the right nose. He had used mercurial inunction and potassium iodide internally up to two months ago, but since then had taken nothing. He reiterated his denial of any injury to the brow or nose, and likewise as to any specific history, of which no stigmata were to be detected. Ten grains of potassium iodide thrice daily over the last four days had, however, caused a rapid shrinking again of the bony swelling.

PROCEEDINGS
OF THE
LARYNGOLOGICAL SOCIETY OF LONDON.

ONE HUNDRED-AND-FIRST ORDINARY MEETING, *December 1, 1905.*

CHARLES J. SYMONDS, F.R.C.S., President, in the Chair.

PHILIP R. W. DE SANTI, F.R.C.S. }
HENRY J. DAVIS, M.B., M.R.C.P. } Secretaries.

SPECIAL MEETING.

A special general meeting of the Society was held prior to the ordinary meeting to consider the report of the Council *re* the union of medical societies.

The reply proposed by the Council of the Laryngological Society to the Central Committee was read by the Secretary to the meeting, and a somewhat lengthy discussion ensued.

ORDINARY MEETING.

At the termination of the special meeting the Chair was taken by Dr. WILLIAM HILL, Vice-President, in the absence of the President.

Present—27 members and 1 visitor.

The minutes of the preceding meeting were read and confirmed.

The ballot was taken for the following candidates, and they were elected ordinary members of the Society:

FRANK ATCHERLEY ROSE, M.B., B.C.Cantab., F.R.C.S. (London).
BENIAL CHANDRA GHOSH, B.A.Cantab., L.S.A. (Calcutta).
THOMAS GEORGE OUSTON, F.R.C.S. (Newcastle-on-Tyne).
JOHN WILLIAM MACKENZIE, M.D., C.M.Edin. (Inverness).

REPORT OF MORBID GROWTHS COMMITTEE.

Mr. Smurthwaite's specimen of (?) Malignant Disease of Larynx, June, 1905. The small fragment presented for examination showed nothing suggestive of malignant disease either of the epithelial or mesoblastic tissues.

Mr. de Santi's Case (?) Malignant Disease of Oesophagus, March,
VOL. XIII.

1905. The Committee considered that the specimen showed no evidence of the case being carcinoma or epithelioma.

Mr. de Santi's Case of Malignant Disease of the Nose, November, 1905.
The specimen was one of round-celled sarcoma.

Dr. Dundas Grant's Case of Malignant Disease of the Antrum, November, 1905. The specimen was one of columnar-celled carcinoma.

The following cases, specimens, and drawings were then shown.

SPECIMEN OF A RHINOLITH.

Dr. WATSON WILLIAMS showed a specimen of a rhinolith removed from a female patient. She had had purulent discharge from the left nasal passage anteriorly for two and a half years, with cacosisma and headaches, the latter were usually central, frontal, and sometimes occipital. The discharge, smell, and the headaches entirely ceased with the removal of the rhinolith. On section, it showed a nucleus that resembled a small dirty piece of cotton-wool. The concretion was composed mainly of phosphate of calcium.

Mr. CRESSWELL BABER asked how long the rhinolith had been in the nose, and whether there was any dilatation of the nasal cavity. In a case of his own there was considerable dilatation, the septum being pushed to the opposite side, and the cheek on the affected side bulged outwards. The patient was a child, and the nucleus consisted of a plug of rag. In another similar case a boot-button formed the nucleus. It was that of a medical man. The rhinolith was removed, and the boot-button found in its centre, which the patient remembered putting into the nose when three or four years old.

Mr. DE SANTI said he had had a similar case at the hospital. A woman at forty-two came with a large, loose body in the inferior meatus of her nose, which had caused considerable ulceration and a discharge of pus. It felt very rough, irregular, and hard, and he took it to be a piece of necrosed bone, but could not find out whence it came, there being no lesion to account for a sequestrum. He tried to extract it, but it was too large, and he told the patient to come again the following week. Then, finding it could not be removed from the anterior naris, an attempt was made to push it back, and it passed into the naso-pharynx, from whence it was easily removed. She had had symptoms four years, but could not recollect having put anything into her nose. When the specimen was examined by the curator of the museum he found the nucleus to be a cherry-stone, which probably had been pushed up during childhood. Probably no inconvenience was felt until various substances became deposited on it. Headache was a prominent symptom, and there was also giddiness.

Dr. JOBSON HORNE said he had had under his care a case similar to the one described by Mr. de Santi, in which previously dead bone, the result of syphilis, had been diagnosed, and the patient had undergone a course of anti-syphilitic treatment without improvement. A rhinolith was found and removed, and the case at once cleared up. The nucleus of the rhinolith was cotton-wool. Some years previously polypi had been removed from the same nostril.

Dr. WATSON WILLIAMS, in reply, said that although there was always a nucleus, in such cases it was often only micro-organisms or natural secretion, such as in broncholiths. There was dilatation of the nasal chamber but no deviation of the septum; it was the inferior turbinal which suffered. It was interesting to hear of the association of headache in most of the cases.

CASE OF TUBERCULOUS ULCERATION OF THE NOSE, HEALED UNDER
TREATMENT.

Shown by Mr. H. BARWELL. The patient, an unmarried woman, aged twenty-nine, was shown before the Society in June, 1905. There was then an ulcer of characteristic tuberculous appearance on the left anterior part of the septum, and a smaller ulcer opposite on the outer wall, as well as a soft granular patch on the left middle turbinal, which bled readily when touched. There was definite pulmonary phthisis, which had since progressed rather rapidly, and lately there had been haemoptysis. She was treated as an in-patient at the Mount Vernon Hospital by the open-air method, and a mixture of lactic acid, formalin, and carbolic acid was rubbed in daily. In August the ulcers were completely healed, a white scar marking the site of the septal ulcer. The condition remained unchanged. A gloomy prognosis had been given when the case was first shown before the Society.

Dr. STCLAIR THOMSON asked how one was to distinguish between tubercular ulceration of the nose and lupus of the nose. The fact that the patient had phthisis did not justify calling the nasal condition tuberculous. One knew that tuberculosis and lupus had, pathologically, the same foundation; but clinically it was easier, with some experience, to distinguish between lupus and tuberculosis in the pharynx or larynx than in the nose. In 1897 he showed a case in which there was distinct lupus in the larynx, but the patient had tubercle bacilli in the lungs.¹ In 1897 Dr. Watson Williams showed a young woman with what appeared to be tuberculoma of the septum, a bluish tumour, and it was shown with drawings and specimens.² Under Dr. Watson Williams she was treated in Bristol Infirmary, and reacted violently to tuberculin. He (Dr. Thomson) saw her later in London, and showed her at the Clinical Society, after which he found he was honoured in foreign literature as showing the first case of tubercle of the nose recorded in English literature. That was a double mistake, because Dr. Watson Williams was the first to show the case, and, secondly, because it was not tubercle, for she now had typical lupus of the nose. A great deal of the septum was lost, and the disease had slowly spread over the turbinals. But the patient was in a fine condition of general health, and was now a healthy woman at twenty-eight, and married. Therefore he was inclined to agree with what had recently been said by Escat,³ namely that the only

¹ *Proceedings*, February, 1897.

² *Proceedings*, April, 1897.

³ *Annales des Maladies de l'Oreille*, vol. xxxi, No. 10, 1905

form of tubercle met with in the nose was lupus. It was generally agreed that acute tuberculosis of the pharynx—that rare but very painful disease—was unknown in the nose. The question he wished to raise was whether tuberculous ulceration in the nose, even in a phthisical patient, was not always lupus.

Dr. WATSON WILLIAMS said he had been interested to hear the upshot of his own case referred to by Dr. StClair Thomson. He thought it was an excusable mistake to call it tuberculoma instead of tuberculosis. He considered it was still an open question whether lupus was pathologically identical with tuberculosis.

Dr. JOBSON HORNE said that if the larynx was free that would be further evidence of the lesion in the nose being lupus, because lupus spread downwards and tubercle upwards, as Escat had pointed out in the paper referred to by Dr. StClair Thomson.

Mr. BARWELL, in reply, said that it was difficult to answer questions on such a thorny subject. There was no tubercular affection of the larynx. He was aware of Escat's paper, and knew that opinions differed on the subject as to whether lesions in the nose should always be called lupus, or whether tuberculosis could be distinguished. The case shown recalled to Mr. Symonds his own case, as it looked very similar. It was one of pure ulceration, rather deep, excavated, without any cicatrisation in one part, and without nodules or any large formation of granulations. That, with the rapidly advancing phthisis, made the diagnosis of tuberculosis more justifiable as distinct from that of lupus. Many regarded the prognosis of that case as bad, and now that it had healed it was not surprising to find a greater inclination to accept the diagnosis of lupus. No one in June suggested it was lupus. One could only accept the result as a criterion and call it lupus because it had healed. No bacilli were found, but scattered atypical giant cells.

CASE OF LUPUS OF THE LARYNX AND UVULA, HEALED UNDER TREATMENT.

Shown by Mr. BARWELL. The patient, a girl aged fifteen, was first seen in March, 1905; the epiglottis was thickened, the characteristic nodules extending along the right ary-epiglottic fold, with redness and ulceration of the cords; the uvula was also affected. He proposed to treat the case with frictions of lactic acid and formalin, and to excise the epiglottis if necessary. Whilst the patient was awaiting admission, the condition improved so much under arsenic that no local treatment was employed, and under good food, open air, and arsenic, the lesions had apparently healed. The nodules had mostly disappeared without ulceration, leaving the peculiar pitted appearance which had been described by McBride.

Dr. STCLAIR THOMSON said Mr. Barwell stated that the condition had healed without local treatment, though he admitted he had not seen the case recently. It was not completely healed, as apple-jelly spots were visible on one arytenoid and on the epiglottis. It showed how sceptical one ought to be before claiming results. He could show two patients

who had entirely lost their epiglottis, evidently from lupus which had completely healed. The patients were unconscious of anything the matter with themselves, and had never had treatment. If they had been under treatment it would have been easy to attribute the result to the treatment. In such cases as Mr. Barwell's, where the condition hung fire, he strongly recommended the galvano-cautery, especially in the case of people who could not afford prolonged and expensive treatment.

Dr. JOBSON HORNE said that some years ago, whilst house-physician at St. Bartholomew's Hospital, and subsequently whilst casualty physician, he had examined the larynx in all cases presenting lupus of the face. In 9 per cent. of such cases the larynx also presented evidence of lupus. The striking point of the investigation was that symptoms referable to the larynx were so often absent when that organ was also involved.

Mr. BARWELL, in reply, said he had been very careful to say "healed *under* treatment," not "by treatment," but he thought treatment had something to do with it. The case was getting rather rapidly worse when first seen, and hoarseness was increasing, and there was a rapid improvement after commencing treatment, but he could not claim that even open-air treatment, good food, and arsenic would produce a cure in any large proportion of cases. He was not aware there was any ulceration remaining now, but he had not seen the case recently. There were one or two apple-jelly nodules on the uvula and on the arytenoid, but compared with the condition months ago, there was a remarkable improvement.

CASE OF SYPHILITIC GRANULOMATA AND STENOSIS OF THE LARYNX. THYROTOMY PERFORMED.

Shown by Mr. de Santi. The patient was shown by Mr. de Santi in November, 1902; the symptoms were hoarseness, slight pain, and difficulty in breathing. Both vocal cords, especially the left, were the subjects of chronic inflammation. On the left cord was a large, firm, red, sessile outgrowth; in the interarytenoid space was a large swelling, presenting cicatricial changes. The patient had been under Mr. de Santi four years previously for secondary syphilis, and amongst other manifestations had syphilitic laryngitis. He attended fairly regularly for about nine months and was then lost sight of. Subsequently he had been under Dr. Powell, who made several ineffectual attempts to remove the excrecence endolaryngeally. He had been treated with large doses of iodide.

When exhibited before the Society the case was confused with another shown by Mr. de Santi for pachydermia laryngis, and no suggestions were made as to operative treatment. Mr. de Santi at the time was of opinion that laryngo-fissure should be done and the growths and cicatricial tissue cleared away. The patient was advised to that effect, but refused operation. His breathing, some

months later, became so embarrassed that he consented to have the operation performed.

Mr. de Santi therefore performed thyrotomy, and removed the growth attached to the left cord and the cicatricial tissue in the inter-arytenoid space. The patient made an uneventful recovery, and was now brought before the Society to show the result. His voice was excellent, as also was the breathing. The growth removed from the left vocal cord was shown. It was as large as a small walnut, and consisted of exceedingly tough tissue. Mr. de Santi had come across several cases of tertiary syphilitic affections of the larynx characterised by multiple nodular out-growths, as well as the more common cases of syphilitic stenosis due to old ulceration and subsequent cicatrification, and was of opinion that in most of them laryngo-fissure should be performed. In his cases operated on the results had all been good.

SCLEROTIC HYPERPLASIA OF THE PHARYNX AND NASO-PHARYNX.

Shown by Dr. BROWN KELLY. The patient was brought to Dr. Kelly in August, 1899, on account of enlargement of the uvula. He was then thirty-four years of age. For about eight years he had been subject to slight attacks of sore throat, and for three he had experienced gradually increasing discomfort, sometimes amounting to "choking fits," due to the uvula either coming forward on the tongue or passing down behind the epiglottis. In addition, nasal respiration had been partially obstructed for a year.

On examining, the uvula was found to be greatly increased in all its dimensions, and to conceal the parts behind. The posterior wall presented a narrow tract of apparently normal tissue running down the middle, and a broad, prominent band on each side, passing upwards into the naso-pharynx, and downwards towards the larynx, and extending outwards so as to incorporate with it the corresponding posterior faucial pillar.

Examination of the naso-pharynx, which was only possible after uvulotomy, revealed a great reduction in its lumen. This was due partly to thickening of the soft palate, and partly to the continuation upwards over the posterior-superior wall of the broad bands just referred to. The thickening on the roof was least in the middle and most marked at the sides.

In the laryngeal mirror the bands on the posterior wall of the

pharynx were seen to pass downwards, and to overhang the arytenoids and posterior parts of the vocal cords.

The thickenings in all these situations were pale, smooth, and moderately firm.

The greater part of the uvula was removed and since then the patient had considered himself cured.

From the tissue removed sections were prepared, one of which was exhibited. The microscopic appearance had been described and the case reported in the 'Lancet,' April 6th, 1901. Dr. Ferguson, Professor of Pathology in the Medical School, Cairo, summarised the whole condition, from the point of view of its morbid histology, as a chronic hyperplasia of the interstitial tissue of the parts involved, of apparently progressive character, with no tendency towards degeneration, and unassociated with the presence of any specific micro-organism.

The patient's personal and family history threw no light on the origin or nature of this affection. No relation to rhino-scleroma, tertiary or hereditary syphilis, or tuberculosis could be established.

The changes that had taken place in the past six years altogether amounted to a slight increase in the roominess of the naso-pharynx and a diminution in the size of the uvula and of the right lateral pharyngeal band.

Dr. DUNDAS GRANT said it was a very interesting, but puzzling, case. It seemed to resemble some of the cases of indeterminate chronic oedema of the larynx, of which several instances had been shown before the Society. He had exhibited one such, with a gigantic infiltration of the ary-epiglottic folds, with swelling of the epiglottis, and no one seemed able to give any explanation of the condition. One could eliminate syphilis and tubercle, and when Dr. Hajek was in London he suggested it might be a form of lymphadenoma, and that arsenic would be a suitable treatment. But if his (Dr. Grant's) interpretation of the histological report in Dr. Kelly's case was correct, there seemed to be no connection with such a condition.

Dr. PEGLER said he should like to see a section which supported Dr. Brown Kelly's diagnosis of sclerosis a little more fully. The specimen on view showed rather an oedematous condition of the stroma, and no fibrous tissue. It was stained with methyl blue without a counter-stain, and apparently for micro-organisms. He agreed with Dr. Grant that the clinical appearance pointed rather to an oedematous condition of the tissues.

Dr. SMURTHWAITE said he had had a case of nasal polypi; there was in addition to the polypi what he took to be a boggy mass high up on the septum—from which it was growing—on a line with the anterior end of the middle turbinal, and having no connection with the latter. Under an anaesthetic he removed the polypi and a large piece of this mass, which was practically hard fibrous tissue. A section under the microscope

showed there was mucous membrane with marked increase of fibrous tissue. Could Dr. Kelly's case not be of a similar nature?

Dr. BROWN KELLY, in reply, said he would be pleased to accede to the suggestion of Dr. Pegler, and, if desired, refer the specimen to the Morbid Growths Committee. Sir Felix Semon recently wrote a paper on the subject, and referred to three cases observed by him, and to the case shown to-day, all of which were apparently of the same nature. Sir Felix Semon took exception, however, to the word "sclerotic" in the term applied to the affection, but he (Dr. Kelly) believed that the clinical course and histological appearances justified its use.

**TWO BEAUTIFUL SKETCHES OF MULTIPLE TELANGIECTASIS OF THE SKIN
AND MUCOUS MEMBRANE OF THE NOSE AND MOUTH.**

Shown by Dr. BROWN KELLY.

CASE OF CHRONIC PHARYNGITIS WITH POLYPI OF UVULA.

Shown by Dr. PETERS. A. H—, aged seventeen, cashier, had suffered with chronic pharyngitis and rhinitis for three years. During this time she noticed that her uvula was much elongated. Occasionally during deglutition it troubled her; otherwise its presence was not noticeable. The uvula was in all $1\frac{1}{4}$ inch in length, and somewhat oedematous. The proximal inch contained muscular tissue, and the last $\frac{3}{4}$ inch terminated in a papillomatous-looking mass $\frac{1}{4}$ inch in diameter. There was also a smaller similar excrescence $\frac{1}{2}$ inch in length at the junction of the uvula with the soft palate. Usually the main appendage clung to the right anterior pillar and lay curled in the right glosso-epiglottic pouch.

Dr. DUNDAS GRANT remarked on the absence of inconvenience from such a gigantic uvula. A similar case had been previously shown, and he had seen one or two in his own practice, with a long uvula, which seemed to tail down into the glosso-epiglottic vallecula, and almost into the hyoid fossa, but producing no discomfort. Doubtless the parts became habituated to the perpetual contact. If Dr. Peters were to remove a small portion, it would be interesting to know whether the patient felt such disturbance as often accompanied the more moderate degrees of elongation of the uvula.

Dr. H. J. DAVIS said that some years ago he showed a case of an old man¹ where the uvula was so long that it practically hung like a pigtail into the glottis. As there was no discomfort from it—and the patient very infirm—he left it alone. He had observed that if the uvula was very long and pendulous there was often not much discomfort, but should it happen to be only a little longer than usual there was often a great deal. In such cases there was often trouble in the nose in the form of nasal obstruction, and if that were attended to the uvula would sometimes shorten of itself. He looked upon it as an indication of nasal obstruction. The present case with the polypi was very unusual.

¹ *Proceedings*, March, 1901.

Dr. PEGLER described a peculiar abnormality of the uvula which he had recently seen in his clinic. The body of the uvula was rather long to begin with, but was joined by a thread-like connection a quarter of an inch long to an oblong body about the same length. In spite of the curious excursions of this growth with every movement of the soft palate the patient was unconscious of its existence and had no symptoms attributable to it.

Dr. WESTMACOTT said if removal was decided upon it might be well to deal with the tonsils also.

Dr. PETERS, in reply, said he used the term polypus because he thought it consisted principally of fibrous tissue. He proposed to remove it and cut sections.

CASE OF SWELLING OVER THE LEFT SUPERIOR MAXILLA IN A MIDDLE-AGED WOMAN (formerly shown).

Shown by Dr. DUNDAS GRANT. Since the last meeting the patient had continued to take anti-specific remedies with regularity. There was free discharge from the nose, but the swelling over the superior maxilla had diminished considerably, and the patient subjectively much relieved; although the numbness of the lip had not entirely disappeared, it was less than formerly. There was decidedly less infiltration of the skin over the swelling, and, under the circumstances, the exhibitor thought that the Society would consider him justified in still delaying operation.

Mr. DE SANTI said the experience mentioned by Dr. Grant was not uncommon. The pathologist not infrequently reported that the condition was malignant, yet the disease cleared up under iodide of potassium. Or he would say it was syphilitic and it turned out to be malignant. Some time ago a man under Mr. de Santi's care had a growth of the external auditory meatus, which was clinically a typical epithelioma. He excised a large piece and sent it for examination, and received the laconic answer, "epithelioma." The man had secondary syphilis at the time. The condition had come on much more rapidly than malignant ulceration would, and there was an absence of enlarged glands. A week after the administration of mercury and iodide of potassium the patient returned with the growth half its former size. If he had not been in the hospital it would have been regarded as cancer. The growth was a huge condyloma. In March he showed a woman with epithelioma of the larynx and pharynx, which had been pronounced simple; but the woman was now dying of carcinoma.

Dr. PEGLER said that the Morbid Growths Committee had very carefully considered the specimens submitted to them, and both of them, especially Mr. de Santi's case, presented considerable difficulty. In the latter case they could only speak from the specimens of tissue under consideration, which they ultimately concluded were not carcinomatous, whatever might be the clinical behaviour of the growth. Dr. Grant's case was a fairly typical papillomatous spheroidal cell carcinoma, of which other specimens, malignant in character, were in the cabinet.

Mr. WAGGETT said that the specimen was similar to others he had seen which ran a malignant course.

Dr. WESTMACOTT said he had three similar cases, in which the clinical and pathological diagnoses were at variance. One was constantly encountering the same difficulty with regard to morbid growths, even where examinations were made by skilled pathologists at more than one centre. There should be a more definite scheme, either for getting a more suitable piece of tissue for examination or for having a more definite form report.

Dr. DUNDAS GRANT, in reply, said he felt justified in watching the case a little longer; possibly it might even yet confirm the report of the pathologist. It would be a great matter if the sections which had been before the Society for some time as doubtful cases could be brought up and reconsidered in the light of their subsequent histories, if these could be obtained, so that the morbid anatomy of those parts could be better established. The pathologist realised that there were microscopical as well as clinical difficulties in diagnosis. Dr. Grant asked whether the Committee thought the microscopical appearances in this case so absolutely typical as to exclude all doubt.

A CASE OF TERTIARY SYPHILIS OF THE LARYNX.

Shown by Dr. G. C. CATHCART.

Mr. DE SANTI said he had had a few such cases at different times, on all of which he operated because of their trouble in breathing, by laryngo-fissure. The present patient would be well advised to have her thyroid split, the growths removed, and the parts trimmed up, especially using Waggett's thyrotomy cutting forceps. The ultimate result would be most excellent.

RECENT NASAL POLYPUS AND SINUSITIS IN A PATIENT WITH LONG STANDING ATROPHIC RHINITIS.

Shown by Dr. WILLIAM HILL (in the chair).

Dr. WATSON WILLIAMS said the two conditions became associated but were not interdependent. It was difficult to know what to do. He had a case of atrophic rhinitis in whom he had opened both antra and washed them out for a long period. But the patient went to someone else, who did a double radical antral operation. This patient was good enough to return and show himself as cured.

Mr. WAGGETT did not think the case to be one of atrophic rhinitis.

Mr. STUART Low said that he had recently had a similar case in private, the patient being a lady aged fifty years. She complained of excruciating pain in the area supplied by the infra-orbital nerve and the ramus subcutaneus malæ. Polypi were found in the opposite nostril. Antral transillumination on the painful side showed only partial dimness. There was no pain on pressure on the antral wall, but on pressing the finger upon the floor of the orbit downwards considerable pain was elicited. He was undecided whether to perform evulsion of the infra-orbital nerve or a radical antral operation. He, however, preferred first to explore the maxillary antrum, and found it packed with soft mucous polypi. There had been no recurrence of the severe pain, and the cure was complete. There were no crusts in the nostrils, but only a condition of rhinitis sicca. He could not find any crusts in Dr. Hill's case.

REPORT ON THE FATAL TERMINATION OF THE CASE OF INCRUSTATIONS IN
THE TRACHEA, WITH AT TIMES WELL-MARKED STENOSIS; SHOWN BY
DR. EDWARD LAW AT THE MEETINGS OF THE SOCIETY ON NOVEMBER
4 AND DECEMBER 2, 1904, AND MARCH 17, 1905, AND DULY
REPORTED IN THE "TRANSACTIONS."

Dr. Edward Law saw the patient on May 30 after a visit to the seaside of seven weeks' duration. The general health was good, but the difficulty in breathing continued and varied in intensity. The crusts in the trachea were less marked than usual. The patient returned home, and the following communication was written by her aunt:

"After seeing Dr. Law on Tuesday, May 30, the patient remained in her usual health until Saturday morning, June 3, when she had breakfast about eight o'clock. She laughed and talked to her sister for some time and then went to a boxroom and knelt down to look in her trunk, asking a little girl who was with her to go away. The patient immediately followed the child and put her arms on her aunt's shoulders, looking at her as if she wished to say she was choking. The mouth was wide open, but she was quite unable to speak, and instantly became discoloured. The eyes rolled, the teeth were set, and the throat was hard and rigid. She neither struggled nor made a sound, and was dead before her uncle could reach her, although he was only at the bottom of two small flights of stairs."

The aunt considers that under no circumstances could anything have been done, as it all happened so very suddenly, the time from speaking to her little girl until the patient was dead being scarcely two minutes.

Dr. Law asked the members not to confuse this case with the one of excrescences, incrustations, or chalky deposits low down in the trachea shown by himself at the meeting of the Society on May 2, 1902, and at the annual meeting of the British Medical Association in Manchester on July 30, 1902.

REPORT BY DR. G. C. CATHCART.

"A *post-mortem* examination was made three days after death. The whole corpse was swollen, owing to *post-mortem* decomposition, the features being unrecognisable and the neck obscured behind the swollen chin and breast, which met in front of it. Blood and mucus were exuding from the mouth and nostrils; the general aspect

resembled that of a death from drowning. The larynx and trachea were removed *en masse* through the usual median incision, and preserved in 5 per cent. solution of formalin. No other organs were examined, permission for a partial autopsy only having been obtained."

REPORT BY DR. JOBSON HORNE.

"For the opportunity afforded to us of seeing the larynx and trachea, we are indebted to Dr. G. C. Cathcart who performed the autopsy.

"The larynx with the trachea was removed seventy-eight hours after death. It was found to be occupied with a membranous material which was present in sufficient quantity to account for death. Owing to the advanced *post-mortem* changes it was impossible to conduct usefully any bacterioscopic or histological investigation with a view of ascertaining the nature of this material. The specimen had to be placed immediately in a strong solution of formalin. When hardened it was opened in the usual way, and presented to the naked eye no morbid appearances apart from those due to *post-mortem* changes."

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

FOURTEENTH ANNUAL GENERAL MEETING, *January 12, 1906.*

CHARTERS J. SYMONDS, President, in the Chair.

Present—22 members.

The minutes of the last Annual General Meeting and of a Special General Meeting, held on December 1, 1905, were read and confirmed.

Dr. Middlemass Hunt and Dr. H. Smurthwaite were appointed scrutineers of the ballot, and the following officers were elected for the year:

President.—Charters J. Symonds, F.R.C.S.

Vice-Presidents.—F. Wilcock, M.D., J. B. Ball, M.D., William Hill, M.D., P. Watson Williams, M.D.

Hon. Treasurer.—H. B. Robinson, F.R.C.S.

Hon. Librarian.—StClair Thomson, M.D.

Hon. Secretaries.—H. J. Davis, M.B., W. Jobson Horne, M.D.

Council.—Felix Semon, K.C.V.O., M.D., Philip de Santi, F.R.C.S., J. Middlemass Hunt, M.B., S. Paget, F.R.C.S., Atwood Thorne, M.D.

The following Reports were read and unanimously adopted:

REPORT OF THE COUNCIL FOR THE YEAR ENDING JANUARY 12, 1906.

The meetings held in 1905 have been of the usual number and have been attended by an average of thirty-two members.

The number and quality of the cases and specimens shown has been well up to the level of former years.

The session 1905 will ever be memorable in the annals of the Laryngological Society of London by virtue of the celebration by the Society of the Centenary of Señor Manuel Garcia, and of the Jubilee of the discovery of the laryngoscope by the famous maestro. The ceremony took place on March 17, 1905, the date of the distinguished honorary member's one hundredth birthday. In the morning addresses were presented by numerous musical and learned societies. A special meeting of the

Laryngological Society was held in the afternoon, graced by the presence of a large number of distinguished foreign laryngologists. The banquet in the evening was attended by over 400 guests.

A Special General Meeting of the Society was held on Friday, December 1, 1905, to consider the Report of the Council *re* the Union of Medical Societies, and after considerable discussion a suitable Report was drawn up and passed.

During the past session the size and printing of the *Proceedings* have been altered in accordance with an arrangement entered into with the JOURNAL OF LARYNGOLOGY. The arrangement has worked well, and has fulfilled its object—namely, an economy to the Society in printing expenses.

There have been two resignations and one death, and eight new members have been elected during the year 1905.

THE HONORARY TREASURER'S REPORT.

The finances of the Society are in a sound state. The reduction of the balance from £27 14s. 1d. to £1 14s. has been caused by the payment of several outstanding accounts for 1904, and by an increased rental. All the accounts for the year 1905, I am pleased to say, are paid.

BALANCE SHEET, 1905.

INCOME.		EXPENDITURE.	
	£ s. d.		£ s. d.
Balance January, 1905	27 14 1	Rent	52 10 0
Subscriptions	138 10 11	Stamp for New Lease	0 5 0
Entrance Fees	8 8 0	Reporting	21 13 10
Sale of <i>Proceedings</i> , etc.	5 14 4	Preparing Index	2 12 0
Interest on Deposit	2 5 9	Annual Dinner	4 4 0
		Pathological Committee	0 9 0
		Baker—Microscopes	4 19 2
		Adlard—Printing	68 8 1
		Pulman	0 3 6
		Hodgkinson	0 7 7
		Martindale	0 3 8
		Wallas	0 3 0
		Mathew (porter)	2 0 0
		Garcia Testimonial—	
		Curator	1 16 8
		Wyon	7 7 0
		Berlin Photo. Society	5 5 0
		Watson	0 12 0
		Bank Charges	0 19 2
		Secretaries' Expenses	5 18 4
		Treasurer's	1 2 1
		Balance	1 14 0
	<hr/> <u>£182 13 1</u>		<hr/> <u>£182 13 1</u>

Deposit at Bankers (London Joint Stock Bank) £150.

Examined and found correct,

ATWOOD THORNE,
E. H. PETERS, } *Auditors.*

January 11, 1906.

HY. BETHAM ROBINSON, *Hon. Treasurer.*

THE HONORARY LIBRARIAN'S REPORT.

The Library and all arrangements connected with it continue to be very satisfactory. These arrangements, and the list of our Exchanges, are the same as detailed in the Report of January, 1905.

By curtailing the number on our Free List we have been able to effect considerable economy, and by the sale of back numbers and cases for binding the Society has added £5 14s. 4d. to the credit side of the Treasurer's Report.

Our thanks are due to Sir Felix Semon for presenting the bound volume of the *Centralblatt für Laryngologie* for the year 1905, and to the editors for a similar gift of the JOURNAL OF LARYNGOLOGY.

Dr. Birkett, of Montreal, has presented the volume edited by Dr. Jonathan Wright on "Diseases of the Throat, Nose, and Ear." Other contributions are appended to this Report by the Assistant Librarian of the Royal Medical and Chirurgical Society, Mr. Archibald Clarke, who has kindly seen to the cataloguing and distributing of our books.

LIST OF DONATIONS.

Presented by the Author.

1. **Malignant Disease of the Larynx** (Carcinoma and Sarcoma). By Philip R. W. de Santi. London, 1904.
2. **Laryngeal Phthisis, or Tubercular Laryngitis.** By Richard Lake. Second edition. London, 1905.
3. Un cas d'hémiplégie droite du larynx et de la langue avec paralysie du sterno-cléido-mastoïdien et du trapèze du même côté, suivie d'hémiplégie totale passagère du côté gauche du corps. (Extr. de la Presse Oto-laryngologique belge, No. 2, 1905.) Par A. G. Tapia. Bruxelles, 1905.
4. Een door operatie geneogene hersenabsces. (Overgedrukt uit het Nederl. Tijdschrift v. Geneeskunst, Jrg. 1904, Dl. ii, No. 23.) H. Burger.
5. Disturbi psichici ed otopatie. (Estratto della Gazzetta degli Ospedali e delle Cliniche, N. 40, Anno 1905.) Per Vittorio Grazi. Milano, 1905.

Presented by the Society.

6. **Jahresbericht der Ungarischen Rhino-laryngologischen Gesellschaft**, Band i, 1904. Redigirt von Hugo Zwillinger. Budapest, 1905.
7. **Nederlandsche Keel-Neus en Oorheelkundige Vereeniging.** Twaalfde Jaarvergadering, op 23 en 24 April, 1904, in het Clinicum van Prof. Pel. te Amsterdam. (Overgedrukt uit het Nederl. Tijdschrift v. Geneeskunde, 1904, Dl. ii, No. 5.)
8. **Niederländische Gesellschaft für Hals-, Nasen-, und Ohrenheilkunde.** xii. Jahresversammlung, am 23 und 24 April, 1904, in Amsterdam. (Separat-abdruck aus der Monatschr. f. Ohrenheilkunde, 1904, No. 11.)
9. **Sitzungsberichte der Wiener Laryngologischen Gesellschaft**, 1904. (Separat-abdruck aus der Wiener Klinischen Wochenschrift, 1904, No. 10.) Wien und Leipzig, 1905.

Presented by the Association.

10. **Transactions of the Twenty-Seventh Annual Meeting of the American Laryngological Association**, held at Atlantic City, N.J., June 1, 2, and 3, 1905. New York, 1905.

Presented by the Society.

11. **Proceedings of the Brighton and Sussex Medico-Chirurgical Society for the Session 1904-5**, and the 58th Annual Report. Brighton, 1905.

Presented by Dr. H. Birkett, of Montreal, Canada.

12. A Treatise on Diseases of the Nose, Throat, and Ear, for Students and Practitioners. By various authors. Edited by Jonathan Wright. Vol. ii. Philadelphia and New York.

Presented by the Author.

13. Des végétations adénoïdes chez les nourrissons. (Extr. du Jour. de Méd. de Bordeaux, 1905.) Par E. J. Moure. Bordeaux et Paris, 1905.
14. Contribution à l'étude de la Commotion Labyrinthique par la fondre. Par V. Grazzi.
15. In Memoriam—Professor A. A. G. Guye. By H. Burger.

Presented by the Society.

16. Niederländische Gesellschaft für Hals-, Nasen-, und Ohrenheilkunde. xiii. Versammlung als Subsection des X. Niederländischen Natur- und Medicinischen Congresses in Arnheim, 28 April, 1905. (Aus der Monatschr. f. Ohrenheilkunde, 1905, No. 8).

Presented by the Author.

17. De Keel- Neus- Oorheelkunde als Studievat voor den Aanstaanden Arts. By H. Burger.

Presented by H. Burger.

18. Nederlandsche Keel-, Neus-, en Oorheelkundige Vereeniging. Dertiende (Buitengewone) Vergadering, als Subsectie van het Tiende Nederlandsch Natuur- en Geneeskundig Congres te Arnhem, 28 April, 1905.

REPORT OF THE CURATOR OF THE PATHOLOGICAL COLLECTION.

As hitherto, the members have most generously contributed specimens of their exhibits and private collections to the Society's cabinet. To all these gentlemen, in the name of the Society, I wish to accord my indebtedness, and to assure them of the pleasure it will always give me to display the microscopical preparations in this valuable collection whenever they give me the opportunity.

The following is the list:

A. CATALOGUE REFERRING TO *Proceedings*.

I. Nose and Accessory Cavities.

1. Epithelioma of Nose and Accessory Cavities, December, 1904, vol. xii, p. 18, Dr. Lambert Lack.
2. Bony Tumour of Nasal Cavity (Left Side), December, 1904, vol. xii, p. 17, Dr. Lambert Lack.
3. Squamous Cell Carcinoma of the Nose, March, 1905, vol. xii, p. 75, Dr. Atwood Thorne.
4. Columnar Cell Carcinoma of Antrum, November, 1905, vol. xiii, p. 1, Dr. Dundas Grant.
5. Round-Cell Sarcoma of Nasal Septum, November, 1905, vol. xiii, p. 9, Mr. P. de Santi.

II. Mouth and Tongue.

6. Fibroma of the Tongue, June, 1905, vol. xii, p. 127, Dr. W. H. Kelson.
7. Angioma of the Palate, June, 1905, vol. xii, p. 132, Dr. Lambert Lack.

III. Pharynx.

8. Tuberculous Ulceration of the Pharynx, January, 1905, vol. xii, p. 43, Dr. F. H. Westmacott.

IV. *Larynx.*

9. Sarcoma of the Interior of the Larynx and Thyroid, April, 1900, vol. vii, p. 86,
Dr. Dundas Grant.
10. Epithelioma of the Right Vocal Cord, January, 1905, vol. xii, p. 41, Sir Felix Semon.
11. Squamous Cell Epithelioma of Larynx, February, 1905, vol. xii, p. 56, Mr. P. de Santi.
12. Soft Fibroma of Larynx and Neck, March, 1905, vol. xii, p. 71, Sir Felix Semon.
13. Tubercl^e of Larynx (Arytenoid Region), March 17, 1905, vol. xii, p. 84, Mr. Harold Barwell.
14. Pachydermia of Vocal Cord, June, 1905, vol. xii, p. 129, Mr. H. Smurthwaite.
15. Squamous Papilloma of Left Vocal Cord, June, 1905, vol. xii, p. 135, Dr. Seanes Spicer.

B. SUPPLEMENTARY CATALOGUE.

I. Nose and Accessory Cavities.

1. Bleeding Polypus of the Septum (Granuloma type), Dr. Herbert Tilley.
2. Bleeding Polypus of the Septum (Fibro-angioma type), Dr. Wyatt Wingrave.
3. Bleeding Polypus of the Septum (Soft Cell Fibro-angioma type), Dr. Wyatt Wingrave.
4. Bleeding Polypus of the Septum (Fibro-angioma type), Mr. H. Betham Robinson.
5. Polypoid Mucous Hypertrophy of the Septum, Dr. W. H. Kelson.
6. Lupus of the Inferior Turbinal, Dr. W. H. Kelson.
7. Fibro-Angeioma of the Naso-Pharynx, Dr. Dundas Grant.

II. Mouth and Tongue.

1. Granulomatous Ulcer of the Tongue (two slides), Dr. L. H. Pegler.

Alteration of Rule XIX : "The Annual Meeting shall be held in the month of January, and shall be followed by a Dinner of the members and their friends."

It was unanimously agreed that this rule be altered to "in the month of June" instead of January.

The meeting then adjourned.

ONE HUNDRED AND SECOND ORDINARY MEETING, *January* 12, 1906

CHARLES J. SYMONDS, President, in the Chair.

HENRY J. DAVIS, M.B., }
W. JOBSON HORNE, M.D., } Secretaries.

Present—22 members and 2 visitors.

The minutes of the last ordinary meeting were read and confirmed.

The following gentlemen were nominated for election as ordinary members:

Arthur Evans, M.S., M.D.Lond., F.R.C.S.Eng. (London);
W. Irvine Stewart, M.B.Aberd.
A. Lieven, M.D. (Aix-la-Chapelle).

The following communications were made :

A CASE OF SINUS OF THE CHIN.

Dr. W. H. KELSON showed a woman, aged twenty-five, with a sinus situated in the centre of the tip of the chin; the patient had noticed it about four years, and from time to time it discharged a honey-like fluid. A probe passed upwards and backwards about half an inch; no bare bone could be felt. The question was whether it was due to want of closure of the mandibular fissure or to some other cause, such as diseased bone.

Mr. BETHAM ROBINSON said that, considering the fact that the duration was not more than four years, and the local conditions, he regarded it as inflammatory, and that it was probably connected with a sinus which tracked up to the root of one of the incisor teeth.

The PRESIDENT said such cases were not uncommon in the general Out-Patient room, and he had seen a fair number of them. Scraping-out had been tried, but it had invariably been necessary to sacrifice the incisor tooth. It would be found that the fang was exposed at the bottom of the sinus. The trouble was probably caused by the right central incisor. It did not give rise to any pain.

A CASE IN WHICH A TRACHEAL CANNULA HAD BEEN WORN FOR NEARLY TWENTY-SEVEN YEARS ON ACCOUNT OF INCOMPLETE BILATERAL PARALYSIS OF THE POSTERIOR CRICO-ARYTENOID MUSCLES, WHICH HAD REMAINED UNCHANGED ALL THAT TIME.

Shown by Sir FELIX SEMON. This patient, now aged seventy-four, was shown on April 25, 1879, to the Clinical Society, and his case is briefly referred to in the twelfth volume of its 'Transactions,' 1880, as well as in my paper "On Mechanical Impairments of the Functions of the Crico-Arytenoid Articulation," *Medical Times and Gazette*, 1880. It is the third case of my own referred to in the collection.

When I showed the case before the Clinical Society, the anterior two thirds of the vocal cords remained almost closed on inspiration. The posterior ends suddenly diverged at a remarkably large angle, and left a considerable triangular opening between their borders and the interarytenoid fold. The dyspnœa, however, was considerable enough to necessitate tracheotomy, which I performed in 1879. The cause of the abductor paralysis was perfectly obscure, and has remained so ever since. Later on a slight change took place in the laryngeal appearance. Absolute immobility of the right arytenoid cartilage, with considerable

tumefaction and change of position, supervened, and pointed to ankylosis of the crico-arytenoid articulation having been added to the pre-existent abductor paralysis. With that one exception the condition has remained *in statu quo* all these twenty-seven years, and the case is now shown again as an historical curiosity, illustrating on the one hand that a permanent wearing of a tracheal cannula does not necessarily interfere with the duration and amenities of life, and, on the other, that such grave changes in the larynx as those described may continue for a period so unusually long without undergoing any change and without their cause becoming apparent.

Mr. HERBERT TILLEY said he had already asked Sir Felix Semon whether oedema over the arytenoid cartilages was present before he inserted the tracheotomy tube. Some eight years ago there was a patient in the Great Portland Street Throat Hospital who came with marked dyspnoea, which had to be relieved immediately. He put in a tracheotomy tube, without a general anaesthetic, because the dyspnoea was extreme. A few days afterwards, when the patient was comfortable, it was impossible to see the larynx; there was marked swelling of the mucosa over the arytenoids, and they presented the appearance frequently seen in tubercular disease of that region. He (the speaker) had kept the man under his notice ever since, and he was in excellent health; indeed he was quite stout. There had never been any further trouble since the insertion of the tube. He had often wondered whether it was due to paralysis of the cords, or whether it was a case of rheumatic inflammation of both crico-arytenoid joints. Sir Felix Semon's case was one of much longer standing than his own, but, judging from the history and present appearance, it appeared to be of an almost identical nature. He mentioned it because there were similar but more recent cases going about. Two years ago he saw a medical man who came in a great hurry because of very difficult breathing. Examination of the larynx showed marked oedema over the left arytenoid. For other reasons he gave large doses of salicylate of soda and the usual general treatment for acute rheumatism. A few days afterwards the patient had rheumatism in the left shoulder-joint, and later in other joints of the body, confirming him in the belief that sometimes one met with acute rheumatic inflammation of the crico-arytenoid joints.

Dr. PETERS said he had a case of double abductor paralysis in a woman who had worn a tracheotomy tube for three years. She experienced attacks of oedema of the arytenoids from time to time since, and previous to the tracheotomy, but he thought she was now developing signs of tabes.

CASE OF ULCERATION OF THE PHARYNX (PROBABLY SPECIFIC) PRESENTING UNUSUAL FEATURES.

Showed by Dr. DUNDAS GRANT. The patient was a man, aged twenty-eight, with destructive ulceration of the pillars of the fauces

and both sides of the pharynx, quite superficial though on an area of infiltration on the right side, but extending deeply and presenting very typically the appearance of the breaking down of gummatous infiltration on the left. The exceptional feature in the case was the unusually early date at which the destructive lesions appeared, the initial infection having occurred about eight months previously, when there was no visible primary ulcer, but what appeared to be an ordinary urethritis. There were no secondary appearances on the skin, and the first suggestion that the infection was specific was the occurrence, about seven weeks later, of a sore throat with all the characters of an ordinary-looking tonsillitis, which subsided, leaving behind it a superficial patch on the right anterior faucial pillar, which, however, was not a typical mucous patch. I then had the opportunity of seeing him (August 1, 1905), and in view of the probability of it being syphilitic, recommended that he should be treated accordingly. He improved very considerably until the month of November, when his throat was reported to be ulcerating. He had been taking mercury continuously by mouth, and was then put upon inunctions and moderate doses of iodide of potassium. In spite of this the ulceration persisted, and was accompanied by such pain that the patient was unable to take sufficient food. He got continuously thinner, developed evening temperatures, and such pulmonary symptoms that his medical adviser suspected tuberculosis, there being dulness on percussion at the right apex, whispered pectoriloquy, and moist sounds; the opsonic index was taken and found to be normal; the throat then presented its present appearance, and it was difficult to exclude the possibility of a tuberculous factor in the case, more especially as the patient had been thrown much in contact with a phthisical employer. A portion of the tissue was removed and examined under the microscope, and its structure found to be characteristic of gumma and not of tubercle. There were no bacilli, but abundant staphylococci.

Sir FELIX SEMON said it was curious that Dr. Grant should have brought the case forward on the day when a lecture of his (Sir Felix's) on the same subject was published in the *British Medical Journal*. In that lecture he dealt with the question which Dr. Grant put before the Society—namely whether gummatous phenomena ever developed so shortly after primary infection. He claimed that the subdivision into secondary and tertiary was purely conventional, and that frequently enough they intermingled. In rarer cases tertiary symptoms developed in the first year after infection; he had himself seen two such cases. In Dr. Grant's case the appearance was so typical of gumma on the posterior

wall of the pharynx that he had jocularly made the observation in the other room that if he were examining on this case and the candidate could not say what the condition was, he would not consider it safe to let such a student loose upon the public. What seemed a serious feature of the case was the possibility of an erosion of the vertebral artery, and one should be on the look-out for such a contingency.

Dr. MCBRIDE said the case of Dr. Grant and the remarks of Sir Felix Semon reminded him of an interesting example of the rapid destructive ulceration which might follow a primary syphilitic sore. It was one in which the affection occurred either in late spring or early summer, and he was called to see the patient in July, at the patient's own house, in consequence of which he had no notes. By the time he saw the patient he had lost practically the whole palate. The course had certainly not been longer than two or three months. Therapeutically the case was interesting, because his medical man, quite naturally, had been treating him with mercury. When Dr. McBride saw him he suggested the discontinuance of the mercury and the substitution of iodide of potassium. The ulceration then at once ceased.

Dr. LIEVEN (Aix-la-Chapelle) said he thought the ordinary ways of administering mercury would not do in cases like Dr. Grant's. He would use injections of calomel, which seemed to be a specific for such cases. The term "precocious syphilis" seemed to be applicable to such cases, and they gave rise to great trouble in treatment. Injections ought to be intra-muscular, and should be continued for five or six weeks. For the subsequent treatment inunction could be employed. Calomel injections produced a very rapid effect, and benefit would be revealed in a fortnight's time. Occasionally there were cases in which even that preparation of mercury did not produce any good effect, but caused a reaction in the specific tissue; and that point was brought out by Sir Felix Semon in his lecture. In the cases mentioned by Sir Felix there was produced by iodide an effect which he (Dr. Lieven) spoke of before the German Laryngological Society as a tubercular-like effect; it was followed by a sudden breaking-down of the tissue, with fever. In the first two cases which he saw, independently of Sir Felix's, the nose was affected, and on the day following the treatment there was swelling of that organ. Those cases, as well as Sir Felix Semon's recent ones, were cured by sarsaparilla, known as the Zittmann method. Perhaps that would be tried in the present case if other measures failed.

The PRESIDENT agreed with Sir Felix Semon's remarks, that the old division of the manifestations of syphilis into periods was purely artificial, and that severe ulcerations were sometimes seen in very early stages of the disease. He had been much interested in the remarks concerning treatment, and had found that the dusting on of calomel, or its inhalation, putting three or four grains on a spoon, holding it over a candle, getting the patient to take a mouthful, and blowing it through the nose, did immense good. He had found such cases did better in bed. The sarsaparilla produced much sweating, and that certainly seemed to make other remedies more effective. Sarsaparilla was a very old remedy for syphilis. There was a small dose of iodide in the sarsaparilla as used in Zittmann's method.

Dr. LIEVEN, in further comment, said many doubts had been raised, especially in England, as to the value of sarsaparilla treatment; but he believed that recent observations led to the idea that sarsaparilla had a specific action in syphilis, because it appeared to act in a similar manner to mercury. If the active substance of it, glycosates, were given in large

quantities, it would be likely to cause salivation and enteritis, the former appearing to closely resemble that produced by mercury. He had seen that occur when the patient, in his anxiety to get well, took more than the proper doses.

Dr. GRANT, in reply, said the question in his mind was as to whether there was anything beyond syphilis in the case which led to it taking on a malignant phase at an early period. All had seen the rupial ulceration which sometimes occurred in syphilis, with destructive effects on the ala of the nose, and it had been advised that the specific remedies should be stopped and the patient sent to the seaside. To the suggestion of rest for such cases he would add that of good feeding. In old days, when tertiary ravages were more frequent than now, he had seen cases go from bad to worse, in spite of the fullest doses of remedies. That was so especially in women. But when they began to have good food improvement ensued. A combination which was sometimes very valuable was bark or quinine, and opium, especially in the phagedenic form. He did not know why there should not be a combination of all those remedies. He would ask the medical man in charge of the case to start calomel injections at once.

CASE OF SUPPURATION IN BOTH FRONTAL SINUSES TREATED BY INTRANASAL METHODS, INCLUDING DILATATION OF THE INFUNDIBULUM BY MEANS OF BOUGIES (WITH SKIAGRAM).

Shown by Dr. DUNDAS GRANT. The patient was a gentleman, aged thirty-one, who had suffered from suppuration in the antrum and frontal sinuses, with headache, and difficulty in attending to his work. There were some polypi in the middle meatus, and the anterior extremities of both middle turbinate bodies were removed; the frontal sinuses were syringed out by means of Hartmann's cannula, with considerable benefit. What gave the greatest relief to the headache was the dilatation of the infundibulum by means of the curved bougies exhibited at the meeting. Subsequently the patient learned to introduce a curved Eustachian catheter into each frontal sinus; the position of the instruments *in situ* was shown by means of the skiagram. The patient had so far been free both from discharge and headache, but he still continued the irrigation. He is to present himself at the next meeting of the Society, when more complete notes of his case will be brought forward. (The bougies shown to the Society were made for the exhibitor by Messrs. Mayer and Meltzer.)

Dr. H. PEGLER said he was rather surprised that dilatation of the fronto nasal canal by graduated bougies had not been resorted to earlier by some rhinologists who were anxious to give a more lengthened trial to irrigation before having recourse to surgical means of a radical nature.

Mr. HERBERT TILLEY said he would have thought that mere dilata-

tion of a canal in that way would have but a temporary effect, one lasting only for hours. He thought the general experience would be that irrigation of such cases was very valuable if they could be got in the first month or two of the infection of the cavities. But after the disease had lasted a long time irrigation was not of much use. He tried it in many chronic cases before adopting external surgery, but he had only one case which was absolutely cured by it, namely six months ago, and the patient was still well. The injections used had included peroxide of hydrogen and almost all the ordinary antiseptics, including an iodoform emulsion, which was left in the sinuses for fifteen minutes, with the patient's head hanging over the edge of the table. Dilatation of the canal might be useful in enabling the surgeon to obtain freer entry into the sinus, but the canal would resume its shape a few moments after the withdrawal of the probe.

Dr. PEGLER, in answer to Dr. Tilley, said he conceived the possibility that the tumefied mucous membrane might yield to the effect of pressure by gradual dilatation and thus assist in the method of irrigation.

The PRESIDENT referred Dr. Grant to a similar skiagram which he exhibited when opening a discussion at Portsmouth on the treatment of frontal sinus disease. A fair proportion of frontal sinus cases could be cured by irrigation—*i. e.* where a larger cannula than an ordinary Hartmann's would be admitted. And it was interesting to notice how simply patients could be taught to irrigate their own frontal sinus. A young girl patient of his was doing it now, and last year he had a case with double frontal sinus disease which got well by irrigation. He also had a lady whose frontal sinus was full of pus, and she also was now quite well. He thought more cases of the kind were curable by irrigation than one was apt to think. In answer to Dr. Tilley, he said if patients did their own irrigation he recommended that it should be done twice a day.

Dr. PEGLER suggested that the success of the treatment would depend on the state of degeneration of the mucous membrane. If there were polypoid excrescences in the mucous sac, it would be all but impossible to cure it by irrigation. Was there any means of ascertaining the state of the mucous membrane of the frontal sinus before commencing radical surgical measures, as could sometimes be fairly accurately done in regard to the maxillary antrum?

Sir FELIX SEMON asked whether the question of the treatment of the frontal sinus was not in a sense analogous to that concerning the antrum. He would say emphatically that in his own experience when an opening through the alveolus had been established, and free drainage thus procured, the majority of the patients got well. Of course all depended, as Dr. Pegler had said, upon the condition of the mucous membrane of the affected cavity. If there was considerable polypoid degeneration, the cases did not get well. But he would vouch for irrigation being efficient if the cases were treated by it sufficiently early, and he did not see why the result should not be the same in the case of the frontal sinus.

Dr. J. B. BALL said he did not think the frontal sinus was quite analogous to the maxillary antrum from the point of view of treatment. He used to think that a great many cases of maxillary antrum suppuration could be cured by irrigation, but of late years he thought otherwise. The cases of dental origin were cured in that way when an opening was made in the alveolus and the teeth and stumps were attended to. But the real mucous membrane affection, which was analogous to most frontal sinus suppurations, did not get well, in his experience, with irrigation, unless it was of comparatively recent origin.

Dr. GRANT, in reply, regretted that the patient attended too late to tell his own history, but he had promised to come to the next meeting, and it would be seen how easily he could introduce the catheter into his own frontal sinus. He suggested that Dr. Tilley should reserve his judgment until he had given the method of dilatation by means of bougies a trial. Of course a comparison with the urethra would show points of analogy as well as of difference. There seemed no reason to condemn the principle, although practically it might have some disadvantages. If a patient were to penetrate the cribriform plate, it would be disastrous; the procedure must, therefore, be carried out very carefully. He had been pleased to hear the President's support of intra-nasal treatment, because he (Dr. Grant) had a weakness for it. In some cases, of course, he had to resort to the external operation, and the question was what means there were of knowing what was the condition of the frontal sinus lining in any particular case. He did not think there was anything very definite to go upon, unless numerous polypoid growths were found in the infundibulum, and then it was reasonable to suppose that the condition extended into the frontal sinus, though not necessarily. Some cases underwent almost spontaneous recovery after the removal of the obstructions. He agreed with Sir Felix Semon's remark concerning the antrum, that the cases were much more curable by irrigation than many observers supposed, but he did not think the irrigation should always be continued through the alveolar opening. Those who had found disappointment through the alveolar opening would find improvement or cure if they allowed the alveolar opening to close, and carried on irrigation through the perforation made through the inferior meatus. He hoped Dr. Ball would give the plan a good trial.

A CASE OF ULCERATION OF THE LEFT VOCAL CORD.

Shown by W. H. KELSON. The patient, a man aged twenty-eight, had suffered from hoarseness for about three months. There was no sign or history of syphilis, and the chest had been carefully examined, but nothing abnormal detected. On examining the larynx there was to be seen well-marked ulceration at the junction of the middle and posterior thirds of the left cord, the ulcer having thickened edges the right cord was normal. The mucous membrane of the larynx was anaemic. There were no enlarged glands to be felt. The question was as to the nature of the ulceration and, if tuberculous, whether primary or not.

Dr. McBRIDE thought the appearance of the left cord was typically tuberculous, though in the absence of bacilli it was difficult to dogmatise on the matter.

Sir FELIX SEMON, in reply to a question from the President, said that he was not prepared to formulate a definite opinion at first sight. If the man had been fifty-four years of age instead of twenty-seven, he would, in the first place, have thought of malignancy; there seemed to be too much thickening of the posterior part of the left vocal cord to be easily compatible with tuberculosis, though he did not, by any means, entirely reject the latter view. Of course the age of twenty-seven did not quite

exclude malignancy. He had himself seen a cylindriform carcinoma of the larynx in a man aged twenty-four. He would suggest that as soon as possible a small portion should be removed for microscopical examination.

Dr. A. BRONNER asked whether it could be a case of pachydermia with ulceration.

Dr. H. SMURTHWAITE said the posterior third was thickened and gave one the idea of a pachydermatous condition; but there was no depression on the opposite side, and the cord did not seem to be inflamed. If it were tuberculous, one would expect to find some inflammatory material beyond the ulceration.

Dr. KELSON expressed his gratitude for the suggestions offered, but he could not agree that the other part of the left cord looked normal. Around the ulcer there was a distinct reddened mass, which stood out in curious contrast to the opposite cord, which appeared to be normal.

Subsequent Note by Dr. Kelson.

On January 13, the day after the meeting, tubercle bacilli were found in the sputa, which were very scanty. The larynx having been cocaineised, the left ventricular band was raised with a bent probe, and it was found that the ulceration extended into the left ventricle as far as could be seen. The affected parts were then curetted.

CASE OF ULCERATION OF THE PHARYNX AND LARYNX.

Shown by Dr. BALL. The patient, a man aged fifty-one, was first seen at the end of last May. He had been complaining of very slight hoarseness and discomfort in the throat for two months. He had hawked up a little blood on three occasions. There was some swelling of the left side of the epiglottis and of the left aryepiglottic fold. There was a small and rather superficial area of ulceration at the junction of the epiglottis with the left pharyngo-epiglottic fold. The glands in the left side of the neck were markedly enlarged. The patient was not seen again until last week. The glands in the left side of the neck were very much enlarged, and some enlarged glands were present on the right side also. Behind the left tonsil was an ulcer, elongated from above downwards, slightly raised, with hard base. The epiglottis was uniformly swollen and the left edge ulcerated, the ulceration extending on to the side of the pharynx. The ulceration in this region was not continuous with that behind the tonsil. There was no doubt about the case being epitheliomatous in nature. The points of interest seemed to be the very early involvement of the

glands, and the appearance of an ulcerating mass behind the tonsil, the disease having originated in the larynx.

Mr. BETHAM ROBINSON expressed the opinion that it was without doubt epitheliomatous.

The **PRESIDENT** said that a general hospital perhaps furnished more experience of such conditions than did a special hospital. It was not uncommon for patients to come with an enlarged gland in the neck long before any symptoms or difficulty in swallowing were noticed, in some cases even when one was unable to find ulceration by means of the laryngoscope.

Dr. SMURTHWAITE said he succeeded in catching a momentary glimpse of the larynx. The left half was turban-shaped, and ran into the middle of the epiglottis. It was semi-granular on the surface, and the ulceration looked like a superficial one, probably tubercular. The left tonsil was enlarged, and looked malignant, but he could not see any junction of infiltration between the epiglottis and the tonsil.

Dr. BALL, in reply, said the peculiarity was that it began in the larynx. He feared very few members got a view of the larynx. The epiglottis was swollen and on the left side there was a little ulceration near its junction with the pharyngo-epiglottic fold. It did not look unlike a tuberculous case in an earlier stage—that is to say, last May. The disease in the larynx was not quite continuous with that in the pharynx.

A MICROSCOPIC SECTION OF AN ANGEIO-FIBROMA.

Shown by **Dr. E. A. PETERS**. This consisted of an irregular network of elongated branching connective-tissue cells, with rod-like nuclei and a granular cell matrix. Many young cells gave evidence of rapid growth. Interspersed among the network were dilated vessels of a venous type. The growth was removed from a boy aged seventeen. He had noticed left nasal inspiratory obstruction for three months. There was no history of bleeding. From the front a dark red fixed swelling could be seen pushing forward to the left middle turbinal bone. Under an anaesthetic an oval sessile tumour of about cartilaginous hardness and the size of a split tangerine was found to be present. It was attached to the periosteum of the basi-occipital and basi-sphenoid. The centre of the mass was the union of the basi-occipital and basi-sphenoid. The palate was split in the failure to adjust a snare, and the pharyngeal growth removed by clipping round the base with scissors. The nasal part was cut off by a sharp spokeshave and ring knife. The finger in the choanæ directed the blade and controlled haemorrhage. The patient was in the Trendelenburg position during the operation, and made a good recovery.

Dr. PEGLER said it was a pity the growths could not have been exhibited *in situ*, because they were very uncommon. Only two had been recorded

by the Society, one of them being Dr. Herbert Tilley's. Under the microscope there was no doubt this was an angeio-fibroma, the greater part of the section being made up of fibrous tissue. There was very little literature on the pathology of these tumours of the nasopharynx.

The PRESIDENT said he thought the literature would probably be found under the heading of Pharyngeal Tumours, or Post-Nasal Fibroids. He believed many cases had been described, though possibly not microscopically.

Dr. GRANT asked whether the connection of the growth was completely made out. An interesting point brought out by Dr. Tilley and Dr. Fitzgerald Powell was that the growths seemed to find their way to some extent into the antrum. In a case of his own when he removed it he thought he got it clear away, but it recurred. On the second occasion he made sure by opening the antrum at the same time and scraping it away. Whether it grew from the antrum or not, it had made for itself a large opening in the inner wall of that cavity, and he would be glad to hear whether Dr. Peters' case had that peculiarity.

The PRESIDENT said he had operated upon several similar cases, and it was extraordinary how they absorbed the bony walls of the nose. He had removed them from the sphenoidal sinus and exposed the dura mater, and with success.

Dr. SMURTHWAITE reminded the members that he showed a specimen before the Society two years ago in which the whole of the septum and turbinal bones had disappeared. The large cavity thus made was occupied by polypus *in situ*, springing from the roof of the nose on the right side, and extended over to the left, pressing on the turbinals, which were also almost absorbed. The specimen had been obtained from the dissecting room.

Dr. JOBSON HORNE said he thought one reason why Dr. Pegler found a difficulty in following the literature of the subject was that such growths were formerly largely described under the heading of "sarcomata." They were innocent in course, killing only by pressure and destruction of adjacent parts, not by metastasis. In removing them the all-important point was to get to the mother part of the tumour.

Dr. PEGLER, in reply to Dr. Jobson Horne, said he drew a clear line between the hard growths and the softer ones which Dr. Horne referred to. He had touched upon the two forms of growth pathologically in a recent paper in the *Lancet*. The soft form simulated granulation tissue, and was often mistaken for sarcoma; the other, harder, growth was more angiomaticous, but was closely related to fibroma in his belief.

Dr. PETERS, in reply, said the growth was very hard—almost cartilaginous to the finger and scissors. It apparently was attached by a wide base to the periosteum of the basi-occipital and basi-sphenoid to the left of the median line. It had pushed over the vomer to one side and the left middle turbinal forward.

PROCEEDINGS
OF THE
LARYNGOLOGICAL SOCIETY OF LONDON.

ONE HUNDRED AND THIRD ORDINARY MEETING, *February 2, 1906.*

CHARLES J. SYMONDS, F.R.C.S., President, in the Chair.

HENRY J. DAVIS, M.B. }
W. JOBSON HORNE, M.D. } Secretaries.

Present—30 members and 2 visitors.

The minutes of the previous meeting were read and confirmed.

ELECTION OF ORDINARY MEMBERS.

The following gentlemen were elected as Ordinary Members of the Society—

A. LIEVEN, M.D., Aix-la-Chapelle.
ARTHUR EVANS, M.S., M.D.Lond., F.R.C.S.
G. IRVINE STEWART, M.B., Aberdeen.

The following communications were made :

CASE OF LARYNGEAL ULCERATION IN A MAN AGED FIFTY-FOUR.

Shown by Dr. DONELAN. The patient had suffered at intervals from some pain on swallowing for the previous six months; he was first seen about three weeks ago, when there was an ulcer on the right ary-epiglottic fold. On seeing the patient again that evening a remarkable extension of the ulceration on to the pharynx had taken place. There was no history of syphilis, but anti-syphilitic remedies had been tried. The opinion of the Society was desired as to the nature of the case, and if it were considered malignant whether any operation should be attempted.

Mr. C. A. PARKER thought the swelling was on the posterior wall of the pharynx, not on the tongue. He regarded it as a gumma breaking down on the right side.

Dr. H. J. DAVIS thought, with Mr. Parker, that the condition was a gumma, especially as the patient experienced no pain in swallowing, and

this he regarded as evidence of its being syphilitic rather than tubercular or malignant.

The PRESIDENT asked whether Dr. Donelan had administered any anti-syphilitic remedies in the case.

Dr. DONELAN, in reply, said the ulceration to which he wished to call attention in the first instance was on the right ary-epiglottic fold, which existed three weeks ago. Since then he had had no opportunity of making a laryngeal examination until that evening, and saw the remarkable extension of the ulceration on the posterior wall of the pharynx for the first time. The history of the case extended back about six months. There was no history of syphilis, but the patient had taken ten grains of potassium iodide and a drachm of perchloride of mercury three times daily for three weeks with no apparent beneficial effect. He had been anxious to know whether any member would suggest any operation.

**CASE OF EXTENSIVE SYPHILITIC ULCERATION IN THE PHARYNX OF A
MAN AGED TWENTY-EIGHT, TREATED BY CALOMEL INJECTIONS;
ILLUSTRATING RAPID IMPROVEMENT IN THE PATIENT.**

Shown by Dr. DUNDAS GRANT. The patient had presented himself again to show the very gratifying improvement which had taken place, and which had started within a few days after the first injection of calomel, recommended by Dr. Lieven, and favourably referred to by Sir Felix Semon in a lecture recently published.¹ The result had answered fully to Dr. Lieven's expectations.

The exhibitor had recently had under his observation several cases of specific disease of unusual severity, one in which a young gentleman, otherwise in good health and in favourable surroundings, had suffered from numerous rupeal spots explained by a dermatologist as due to the superposition of staphylococcus infection on the specific one. The same patient had had up till recently an œdematous condition of the left half of the epiglottis and left ary-epiglottic fold. Dr. Grant desired to learn whether members of the Society had observed that specific infection was at present of a more severe type than in previous years.

The PRESIDENT said all would be willing to congratulate both Dr. Grant and the patient upon the immense improvement which had taken place in the interval. He would like to hear what amount was injected and the site chosen.

Dr. GRANT replied that the injection was done in the supra-external quadrant of the buttock, the area marked out by Dr. Lieven for the purpose. He used 15 m of a 1 in 10 suspension of calomel in paroleine. It was done twice a week; it certainly caused some discomfort.

Dr. W. H. KELSON joined in congratulating Dr. Grant on the success of the case, but before commencing to inject obstinate cases of syphilis

¹ *Brit. Med. Journ.*, January 13, 1906.

with calomel he would like to know whether it were true that there had been some disastrous results from this method of treatment.

Mr. PARKER called attention to a recent paper in the *British Medical Journal* by Lieut.-Col. Lambkin, based on an experience of 3000 cases treated by 60,000 injections of mercury in some form. He had found calomel very active, but painful, and apt to set up painful nodules and swellings at the site of injection. He prefers mercury itself suspended in lanolin as being gradually, evenly, and slowly absorbed. After injecting it some 40,000 times he is able to state that he has seen no serious complication of any kind.

Dr. GRANT, in reply, said a paper was published some time ago suggesting that gummata were apt to form at the site of injection of insoluble preparations of mercury, but it seemed to be a very rare occurrence. Dr. Lieven recommended the treatment so confidently that he (Dr. Grant) tried it, and felt indebted to that gentleman in consequence. The discomfort was very small. There was an original paper in the *Journ. of Laryngol., Rhinol., and Otol.*, in which Dr. Lieven¹ described his methods of treating syphilis of the upper air-passages.

Dr. H. J. DAVIS said the interesting point was this: When Dr. Lieven first saw the case he stated that he did not think it would improve with mercury or iodide of potassium, but that he was certain it would improve with injections of calomel. There had been, so far, only six injections, and yet the patient was practically well.

Dr. GRANT, in further reply, asked whether other members had recently seen cases of syphilis of a greater severity than during the last ten or fifteen years. He had seen several.

SONDERMANN'S SUCTION APPARATUS.

Shown by Dr. DUNDAS GRANT. This consisted of a nose-piece with pneumatic borders and an indiarubber bulb with valves so constructed as to only exercise suction. With this he had been able to relieve discomfort by the withdrawal of secretions from the sinuses of the nose. He described a case to which he had been called that same afternoon; the patient complained of excruciating frontal headache of considerable duration. There was seen in the right middle meatus some creamy pus, but the left one was hidden by a swelling of the middle turbinated body, the frontal pain being greater on the left than the right side. After spraying with cocaine and adrenalin, the patient was instructed to hold his nose and make an expiratory action, but this produced little or no effect, whereas when Sondermann's apparatus was applied, while the patient uttered the sound "ee" or "kee," a purulent secretion was extracted and then snuffed back into the throat and spat out. The patient then found himself considerably relieved. The exhibitor considered the instrument a useful auxiliary in the treatment of such cases.

¹ *Journ. of Laryngol., Rhinol., and Otol.*, vol. xviii, p. 225.

CASE OF SUPPURATION IN BOTH FRONTAL SINUSES TREATED BY INTRANASAL METHODS, INCLUDING DILATATION OF THE INFUNDIBULUM BY MEANS OF BOUGIES (WITH SKIAGRAM).

Shown by Dr. DUNDAS GRANT. The patient, a gentleman aged thirty-one, was first seen by the exhibitor in November, 1902, when he complained of daily attacks of dizziness and headache, which he had suffered from for the previous two years, the discomfort being worse after stooping down over his work. Both antra were punctured and the left one was full of pus; there was also a swelling of the anterior lip of the hiatus semi-lunaris and probably suppuration in the frontal sinuses. The next day he was more free from giddiness than he had been for two years. The antrum was punctured through the alveolus, and the patient himself regularly carried out the treatment by irrigation for a number of months, during which he experienced a slight improvement. In September, 1903, he was still conscious of an offensive smell in the nose, and this was worse in the morning. The anterior portions of the middle turbinated bodies were removed, and this was followed after a fortnight by some diminution in the amount of discharge. The frontal sinuses were frequently washed out, at first with glycothymoline and then with a weak solution of formalin, 1 in 4000, then in 1 in 2000 and 1 in 1500. In May, 1904, Messrs. Mayer and Meltzer made for the exhibitor some S-shaped bougies for dilating the infundibulum, and these were used up to the fourth size. Almost immediately after this treatment was started, the headache became so slight that he reported it as quite gone. He soon learned the art of introducing a curved cannula into his frontal sinuses for himself, and had been out of Dr. Grant's hands since the middle of 1904. The skiagram showed the cannula in position.

SUPPURATION OF FRONTAL SINUSES TREATED BY IRRIGATION ONLY.

The PRESIDENT showed the case of a man aged thirty who came under his care for suppuration in both maxillary sinuses, both frontal sinuses, and ethmoidal sinuses. The maxillary sinuses were drained through the alveolus. As a large sized cannula could be passed into the frontal sinuses they were, after removal of a part of the middle turbinal, irrigated. The patient learnt to irrigate the sinuses himself with great facility, and as he had a

considerable objection to any external operation this method was continued; after about six months he returned without any pus being washed out. He had not been seen for nine months, and was shown that day as a patient who had reported himself a few days before as well. On examination it was found that there was pus in both nostrils. This the patient attributed to a cold, but the appearance suggested that there was a recurrence of suppuration, or possibly it never got quite well. The patient, however, demonstrated the fact that it was possible for the sinus to be washed out with great facility, and that at least the suppuration could be reduced to a minimum, and, as other cases had shown, might be completely arrested.

The PRESIDENT said there could be no doubt that his patient had got pus in his nose. The man, who was somewhat careless of his condition, thought it was due to cold. He had not seen the patient for nearly a year.

Dr. DENNIS VINRACE said all would welcome conservative surgery in such cases. He asked incidentally whether the patient was correct when he said he passed the catheter himself the first time. He presumed there was some preliminary operation.

The PRESIDENT, in reply to Dr. Vinrace, said the patient must have meant that he succeeded in passing the catheter the first time he tried. But, of course, he showed him two or three times how to do it.

Mr. E. B. WAGGETT said that the success or failure of treatment by irrigation seemed to depend upon the size and shape of the frontal sinuses. He had many cases treated by this method, the patients using a cannula daily. They did very well and were relieved of symptoms, but, with two or three exceptions, he had not seen a real cure.

Mr. HERBERT TILLEY thought the point raised by Mr. Waggett was a very important one. Another determining factor in the successful termination of any case was the extent to which the neighbouring ethmoidal cells were involved. If the contour of a frontal sinus was fairly regular, and the opening into the nose was free and blocked neither by the middle turbinal nor by large granulations around the anterior ethmoidal cells, that sinus ought to be curable by irrigation and free drainage. But if near the opening of the sinus into the nose there were small suppurating ethmoidal cells which were constantly re-infecting the sinus, one could not expect irrigation to produce a successful result. An excellent illustration of that had recently occurred in a medical friend who had been under his (Mr. Tilley's) care during the past ten days, and who had frontal sinus suppuration. The sinus could be easily irrigated, and this was carried out once daily for a week, but the pain in and around the eye was so great and unrelieved by the irrigation that the sinus was opened, and it was found that although it had been irrigated and was comparatively healthy, yet on the floor of the sinus and near its inner end was an ethmoidal cell from which pus exuded when its cavity was probed. There were other ethmoidal cells under the sinus, and those extended back between the eye and the floor of the frontal sinus as far as the sphenoid. Having made a large opening into the nose and destroyed the cells referred to, the headache disappeared, and he had had

no trouble with the patient since. He sewed up the external wound at once, and had done this in the last four cases which he had operated on during January. Thus one not only cleared the sinus, but those most important ethmoidal cells near its floor were destroyed, so that with immediate closure of the external wound such cases might be discharged in a fortnight. He proposed to show four patients at the next meeting who had been dealt with in the manner described.

Mr. CHICHELE NOURSE said that the treatment of frontal sinusitis through the infundibulum had been a subject of interest to him for some years. He spoke of it at the Portsmouth meeting in 1899. He had been in the habit of using probes and cannulae considerably more curved than those now shown. He had tried irrigation with various liquids, but had never quite succeeded in curing a case by that means. The substances he had found of most value for injection were menthol-valsol (a petroleum preparation) and peroxide of hydrogen solution. In three or four cases he had also tried the plan of introducing a small drainage-tube through the infundibulum by means of a probe shaped like the one he exhibited, upon which two pieces of drainage-tube were threaded. The second piece of tube was used to push the first one onwards into its place. On withdrawing the probe the first piece of drainage-tube was left in the sinus with the end hanging into the nose. At first too long a piece was used, and the patient complained of the free end moving in his nose as he breathed. Accordingly it was gradually shortened. Once it was found to have disappeared entirely into the sinus, but was dislodged by syringing with the oily preparation mentioned above. It was reintroduced and the patient continued to wear it for some time, but eventually it disappeared again, and could not be brought down. As the suppuration was not cured, the sinus was opened in the usual way, and the tube was found lying within it. In subsequent cases he used somewhat longer tubes. After a small tube had been worn for some days, he found that the fronto-nasal canal would admit one of a larger size. However, although it was easy to carry out, he had not found any great advantage gained from this plan. In order to judge whether the probe was in the sinus, a second probe of exactly the same curve and size was laid parallel to the first along the outer side of the nose. On one occasion when performing a radical operation on the frontal sinus, he had introduced one of these probes beforehand through the infundibulum and was able to bring the point out of the frontal wound by depressing the handle. The peroxide of hydrogen solution he used was of the usual strength diluted to one in three.

Dr. SCANES SPICER said he was interested to hear of the reversion to conservative methods. He had always felt rather conservative about the frontal sinus, probably because drainage being so much easier there than in the other sinuses one gave sufficient relief by removing the anterior part of the middle turbinate, freeing the infundibulum and anterior ethmoidal cells so that the sinus was sufficiently drained and improved by intra-nasal operations. He thought unnecessary stress was being laid on intubation of the frontal sinus. If the contents of the anterior ethmoidal cells were thoroughly cleared away, sufficient drainage was usually obtained without actual intubation, which introduced the danger of new or re-infection. At the same time, one must not hesitate to adopt the course Dr. Tilley had rendered popular in cases where there were periodical daily recurrent headaches in which efficient drainage could not be obtained by intra-nasal measures, also where there was septic infection

of the frontal bone, with pain, swelling, and redness externally. There were cases needing external operation in addition to the previously carried out intra-nasal measures. One had had cases under local treatment for many years in which one had become bound eventually to recommend the radical operation. He was very interested in the skiagrams of the tubes *in situ*, though he had not yet felt impelled to get any done of his own cases. With regard to Sondermann's apparatus, he (Dr. Spicer) found one could often exhaust the accessory sinuses, suck out the antrum and frontal sinus by clamping the nose and inspiring strongly with shut mouth. He therefore did not see offhand the need of an apparatus for doing this.

Dr. F. W. BENNETT pointed out that whereas it was difficult to pass a probe into the normal frontal sinus in the case of chronic suppurative lesions it was possible to do it in more than 50 per cent. It could be learned by the patient and easily carried out.

Dr. GRANT, in reply, called the attention of members to the usefulness of the bougies employed in the present case, which he described last time and which aided in preparing the patient for the cannula. Dr. Tilley had well expressed the conditions which one might expect to cure by the treatment. He (Dr. Grant) found quite a sufficient number to encourage such a procedure.

The PRESIDENT, in reply, said that in a certain number of cases where there was pure frontal sinus disease it seemed possible to effect a practical cure. The present case did not represent cure, but the frontal sinus sometimes did get well, even with the removal of the anterior end of the turbinal. He had seen the pus disappear after a couple of washings, and had watched for recurrence without it happening, showing that it was possible for slight cases to recover in that way. In more advanced cases of ethmoidal disease it was necessary to open them up. In answer to Dr. Tilley, he had obtained better results by sewing them up immediately. The present man was operated upon three and a half years ago, and the sinus was washed out through the nose.

CASE OF FIXATION OF RIGHT CRICO-ARYTENOID JOINT DUE TO INFILTRATION, PROBABLY MALIGNANT DISEASE, IN A WOMAN AGED FIFTY.

Shown by Dr. FURNESS POTTER. The patient gave a history of pain and difficulty of swallowing for the last six months, and stated that during this time she had become thinner, otherwise her health had been good. There was no cough and no affection of voice or respiration, no evidence of syphilis. On laryngoscopic examination the region of the right arytenoid cartilage and ary-epiglottic fold was seen to be reddened, swollen, and oedematous. The crico-arytenoid joint was fixed in about the middle line, though on inspiration a flickering movement of the cord was observable which gave an impression as if fixation were not complete; on careful inspection, however, no true movement of the arytenoid could be seen. Examination by the finger gave no sensation of hardness. An

indurated gland could readily be felt immediately behind the angle of the jaw. The chest had been examined with negative result.

During the last few days the patient had complained of considerable pain radiating from the throat to the ear. Potassium iodide had been taken for the last ten days with no appreciable effect.

Sir FELIX SEMON said it was almost impossible to give an opinion on account of the oedema of the arytenoid. But owing to the large gland in the corresponding side and the fixation of the cord, he thought the probabilities were in favour of malignant disease rather than tuberculosis.

Dr. GRANT said the case was almost on all fours with one he showed some time ago, with swelling of the right epiglottic fold, fixing the cord. In the present case the cord was, however, not quite fixed. In his case there was difficulty in swallowing, and he thought at first it was syphilitic perichondritis, but the President's suspicion that it was an extrinsic carcinoma of the lower part of the pharynx and larynx turned out correct. The glands in the present case supported the idea of malignant disease. Perhaps if a definite diagnosis was urgently called for there would be little difficulty in removing one of these glands for microscopic examination.

Mr. WAGGETT said that as oedema was also present on the left side of the cricoid the case was very likely to prove an oesophageal carcinoma; the oesophagoscope should be used before anything further was done.

The PRESIDENT said the case looked like one of epithelioma behind the cricoid, extending up under the mucous membrane. Possibly there would be sprouts of growth there before long.

Dr. FURNISS POTTER, in reply, said the remarks which had been made confirmed his own suspicion. He regarded operation as so much out of the question that he had not mentioned it.

CASE OF INTRINSIC LARYNGEAL NEOPLASM IN A MAN AGED SEVENTY-THREE, SHOWN AT JUNE MEETING, 1905.

Dr. SCANES SPICER described the surface of the anterior half of both cords as covered with dull, rough, patchy areas of yellowish-white colour (? ulceration), with tiny nodular masses projecting, especially on the left cord. There was a slight huskiness, but no cord-paresis, pain, cough, dyspnœa, dysphagia, bleeding, tumour, cachexia, or enlarged glands. The appearances, plus the microscopic diagnosis of papilloma previously made, did not justify the clinical diagnosis of malignancy or call for laryngo-fissure, nor did it appear wise to irritate the larynx by intra-laryngeal measures. The picture was a peculiar one, and as he himself did not grasp its exact significance he would be glad to hear the opinion of the Society.

Sir FELIX SEMON said that if he had seen the case now for the first time his idea would have been that it was a mycosis, not new growth. He suggested that a piece should be again removed for microscopic examination.

Dr. H. PEGLER said the extreme whiteness was explained under the microscope by the character and density of the layer of keratinous cells that covered over the peak-like apices of the papillomatous growth.

The PRESIDENT regretted he had been unable to bring before the Society a lady who showed a similar condition. On the left vocal cord was an irregular nodular growth of peculiar whiteness, but with a movable vocal cord. She had had a similar patch on the right cord, a portion of which was removed and reported to be malignant. This growth had entirely disappeared from the right cord, and without operation. The patch on the left cord was like that in Dr. Spicer's case, only of less degree; it had been present for a year. He would again try to bring the case for inspection.

Dr. Grant pointed out that an almost identical case was illustrated in Krieg's *Atlas*. It was shown there as non-malignant proliferation of the superficial epithelium—a kind of pachydermia or keratoses.

Dr. SCANES SPICER, in reply, thanked members for their suggestions. It did occur to him that the surface appearance resembled mycosis in the tonsil, but in view of the large papilloma which had been removed, and the subsequent ulceration and thickening, and not remembering to have met with mycosis of vocal cords, or read of it, he had not seriously entertained that view until suggested to him by Sir Felix Semon. Perhaps there was a mycotic growth arising on the nidus of the ulcerated papillomatous base. Anyhow, he would remove a small piece, with the patient's consent, and get it examined from that point of view. He was gratified that the Society agreed with him that the appearances and symptoms were not sufficiently those of malignancy to justify an external operation.

A PEDUNCULATED GROWTH OF UVULA IN A BOY AGED NINETEEN.

Shown by Dr. W. H. KELSON. The patient came complaining of running from the nose and was unaware of the presence of the growths, one of which was about the size of a pea, the other of a broad bean, and both were growing from the base of the uvula. They both had pedicles and appeared to be papillomata.

The PRESIDENT asked if they were attached to the base of the uvula. These growths he had not infrequently seen, and had looked upon them as harmless.

Sir FELIX SEMON said that some years ago Mr. Stephen Paget rather alarmed the profession by insisting on the possible malignant transformation of such growths, and since then he (Sir Felix) had, as a matter of precaution, removed them. But he regarded the danger of transformation as exceedingly remote.

CASE OF EPITHELIOMA OF THE NASO-PHARYNX, WITH MICROSCOPIC SECTION.

Shown by Mr. STUART Low. The patient, a man aged forty-four, complained merely of slight deafness in both ears of recent

date. On examination, the soft palate was found to be almost motionless, and in the naso-pharynx a large raised ulcerated surface was discovered on the posterior wall. On palpation this was felt to have a very firm outline and base, giving an almost horny feeling in places. It was ulcerating at certain parts, and bled freely when touched. The naso-pharyngeal canal was felt to be greatly narrowed, and the induration had infiltrated the lateral wall on the left side and the posterior palatal pillars. The hard outline of the growth could also be plainly made out through the soft palate on backward pressure with the finger. There was an entire absence of glandular enlargement. The absence of subjective symptoms was remarkable. There was no discomfort in breathing or swallowing, no pain, no nasal obstruction nor nasal intonation. He said that he had lost a stone in weight in three weeks, and since coming under observation fourteen days ago he had lost half a stone. He had worked for years in a very foul and very dusty atmosphere, being a cleaner and sweeper of railway carriages. His wife had been for some months in a lunatic asylum, and this had worried him very much. He had had a great deal of domestic work to do in addition to long hours of labour, having five young children at home, and being too poor to pay anyone to attend to them. The family and personal history threw no light on the case.

Schmidt had reported having found one case of epithelioma in forty of naso-pharyngeal tumours, but a Spanish writer had recently found as many as five in twenty cases. There was a noticeable predilection for the male sex in these statistics. Mr. Stuart Low remarked that the inveterate cigarette smoking with nasal exhalation of the tobacco smoke by the Spaniards might help to account for this prevalence.

The man was now on 20-gr. doses of iodide of potassium three times a day, but was still losing weight. Mr. Stuart Low asked for the opinion of the members on the feasibility of operation. A piece of the growth had been removed for microscopical examination, and Dr. Wyatt Wingrave had given the following report; the specimen would be submitted to the Morbid Growths Committee for their opinion.

Report by Dr. Wyatt Wingrave.

The growth consists chiefly of closely-packed epithelioid cells channelled in varying degrees by microblastic tissue, so that it is loose in texture in some parts, almost solid in others.

The cells are round, fusiform, or oval, according to their respective position or compression, their nuclei being round or oval, according to the axis of section; several exhibit very irregular, mitotic forms.

The mesoblastic stroma consists of white fibres with leucocytes and lymphocytes, supporting blood- or lymph-vessels whose walls are thickened by fusiform cells. In some parts the lymphocytes are very numerous, and there are groups of multinucleated masses which are probably "fusion" cells.

The growth probably originated in the peri- or endothelium of these vessels, since in some parts the perithelial cells are not only thickened, but appear to be traceable into the neoplastic elements.

It differs from ordinary squamous epithelioma in that there is no tendency to concentric lamination or "nesting" of the cells, and they do not exhibit any horny or keratin changes.

The PRESIDENT thought there could be little doubt as to the nature of it. He could not recall many instances of it, but two were quite familiar to him, both inoperable. One of them came with a lump in the neck, but no complaint about the throat. He found carcinoma in the naso-pharynx. He had many sections of rodent ulcer from various parts of the body, and Mr. Low's section resembled some of them. It demonstrated the importance of post-nasal examination in deafness.

Dr. PEGLER said there was a strong suspicion of malignancy about the case, but the Morbid Growths Committee would report.

CASE OF INJECTION OF COLD PARAFFIN FOR NASAL DEFORMITY.

Shown by Dr. DUNDAS GRANT. The patient, aged twenty-four, was the one whose photographs were brought before the Society in January, 1904, after he had had subcutaneous paraffin injections for rectification of the deformity due to a depression of the bridge of the nose, resulting from injury seven years ago. The improvement in the appearance was then considerable, and as long as he continued in his occupation of ship's steward it appeared to be lasting. Unfortunately, in spite of having been strictly advised to avoid exposure to heat, he became a stoker in the Royal Navy, and was exposed to temperatures of as high as 180° Fahr. The paraffin appears to have yielded and the nose returned to its previous shape. He came under observation again a week ago, and was at once treated by means of an injection of cold friable paraffin by means of Mahu's syringe, the result for the moment being extremely satisfactory and the patient having decided to give up his occupation of stoker, Dr. Grant had some hopes that it

might be lasting. He would be glad to know what had been the ultimate results in the experience of those who had observed such cases, and he proposed inquiring with regard to the few cases he had had under his own treatment, and reporting to the Society. Meanwhile, he recommended the ingenious instrument devised by Mahu, which was a modification and, in his opinion, an improvement upon the original one of Broeckaert, and which, until the invention of a better one, was most probably the most perfect at their disposal. The friability of the paraffin was an important point, inasmuch as it allowed of the breaking off of the thread inside the subcutaneous space instead of its remaining and forming a plug in the needle-puncture in the skin.

Sir FELIX SEMON said he was not an inveterate opponent of any good innovation in surgery, but he would read a translation of the peroration of a recent article by Dr. L. Kirschner, of Berlin :

"It is easy to see the importance of the results gained by these histological investigations with regard to treatment. We have seen that neither of the two kinds of paraffin which are used nowadays therapeutically, neither the hard nor the soft paraffin, belong to the foreign bodies which, subcutaneously injected into the organism, 'heal in'—i. e. heal in in that sense that they form a capsule, which separates them from the rest of the tissue. We must remember that we include under the expression 'healing in' various pathological processes. To choose a ready example—when we use a catgut thread, we understand by its healing in its complete resorption; of a lead bullet, on the other hand, we expect that it heals in by surrounding itself by a connective-tissue capsule in the shape of a mantle. In the one case, therefore, healing in means complete resorption and assimilation of the substance which it is intended to heal in; in the other case it means its complete preservation.

"What kind of pathological process is the injected paraffin intended to produce in order to be therapeutically effective? The injected paraffin is intended to repair deformities, fill up defects, replace, so to say, lost tissue, support sunken-in structures, etc. This task could be lastingly solved by paraffin only if after injection it remained *in loco unchanged in extent and consistency*, if, as has been erroneously supposed, it became encapsulated. We have just seen that the reverse is the case. We may, however, go even further. It would be quite conceivable that the commencing organisation, that is to say, the perforation of the paraffin by connective tissue which unavoidably follows the injection, might be considered as a very desirable process, advancing the therapeutic object. But, as we have seen, the connective-tissue organisation does not become arrested at any given moment; it irresistibly proceeds, following its own laws; it leads to *complete resorption* of the foreign body which has been introduced. Further, we have seen that *both kinds of paraffin* are not at all *lastingly tolerated* in several parts of the body in which they are used with predilection, because they produce severe local tissue disturbances which render their *premature removal* necessary. But even where this does not occur, and where paraffin is being tolerated for some length of time without doing harm to the neighbourhood, a brief consideration of the fate of the young connective tissue which becomes developed during the organisation of this foreign body, viz. the unavoidable change of the inflammatory tissue produced into a shrinking scar, must show more distinctly than anything else how fallacious are the therapeutical surmises which have led to the use of paraffin."¹

The practical conclusion to be drawn from this seemed to be that every surgeon who had made a large number of such injections should ask all his patients some years later to show themselves, so that an opinion could be formed as to the lasting effect of these injections. From

¹ *Virchow's Archiv*, Bd. 182, Heft 3.

the mere fact that failures had not oftener been reported it was obviously unsafe to draw conclusions as to the stability of the primary effect. It was certainly possible that some had been unsuccessful and that the patients had consulted other advisers. He suggested such an inquiry by members of the Society.

Dr. DONELAN said he had had a case over two years ago which illustrated some of the points referred to. A young man had fractured his nose, leaving a saddle-shaped depression. Paraffin of 112° F. melting point was injected. He was quite pleased with the result as regards the nose, but owing to the fracture some of the paraffin worked out at the level of the lower border of left nasal bone forming a curious ridge on the cheek. Every form of heat that could be devised without blistering the cheek was tried so as to alter the shape of this "spur" without effect. At length it was dissected out under aseptic conditions, leaving practically no mark. Under the microscope sections of the removed "spur" showed that it existed in a finely granular condition intimately diffused through the connective tissue. He had used the instrument shown by Dr. Grant to inject the inferior turbinals in a case of atrophic rhinitis. It was much simpler and cleaner than the hot paraffin injections, but he thought the melting point of the paraffin charges was much lower than the degree claimed for them.

Dr. SCANES SPICER reminded members of the case he had shown at this Society, January 10, 1902, with models and photographs before and after, (Cheltenham Meeting, British Medical Association, 1901), the first case of the kind done in England, and the results of which some might remember. In this first case, although the improvement in contour remained, within a year the paraffin wandered into the eyelids, causing oedema of these to the extent of closing the palpebral fissures, with interspersed solid nodules. Not liking to undertake a dissecting operation in the eyelids, he asked his colleague, Mr. Juler, to remove these nodules, and the result was a perfect recovery. He had sections showing paraffin diffused in a molecular spheroidal form; diffraction bands were seen all round the globules imbedded in dense connective tissue. He had injected seven or eight cases altogether, but he became disappointed with the procedure chiefly because of the scalding of the patient by the heated injection cannula and the subsequent pain; in fact, after the first case an anaesthetic was always needed and given. One lad from the country he injected three or four times, and the result was especially unsatisfactory, as the points of injection suppurred in spite of antiseptic precautions, and the shape of the nose remained as before. The use of solid paraffin appeared to be a great improvement. In suitable cases, especially in young women who had the extreme saddle nose of congenital syphilis, he thought paraffin injection would remain a legitimate and useful procedure. He did not think anyone should attempt it for minor degrees of irregularity or to gratify a whim—to convert an ordinary into a Roman or Greek profile. It would be observed that in Dr. Grant's case, as in his own and in most other operators' cases, the result could hardly be described as refined or elegant. He would therefore limit the use of paraffin injection into the nose to cases of gross deformity.

Dr. VINRACE supported the suggestion that those who had adopted the method should report on their cases after a substantial interval. He said it should be borne in mind that these operations were not done in conditions which threatened life, and even from the sentimental point of view he did not know that it was right to give to a girl a semblance

of beauty by which to deceive the opposite sex. He had not yet seen an instance of the operation where it seemed to have been justifiable, and he would be delighted to see cases where it had been done some years ago with satisfactory and permanent results.

Sir FELIX SEMON desired to ask why, when a quantity of this new cold and soft paraffin was injected into the nose, or any other part, it was supposed that the paraffin would remain stationary, as moulded by the surgeon at the operation? When the paraffin was put from the bottle into one's hand it could be moulded to any form. He would have thought that even such pressure as that exerted by a pillow at night time on the nose would interfere with its form, and, of course, much more so a blow or fall, causing more serious disfigurement than had existed before the injection had been made.

Dr. GRANT replied that it was his intention to get the records of such cases. He had not done many of them. He did not think anybody professed that the form of paraffin he had just shown would be more solid or even as solid as those with a higher melting-point. The great point was the immense convenience of being able to inject it without heating and without scalding the patient. It could be done under cocaine. It had been said that the ease with which it could be done would enable quacks to do it, but that was scarcely a scientific objection. As to the propriety of having it done, if one were similarly disfigured oneself one would be glad to have it used, and that was surely a good reason for giving others the benefit of it, even if at the end of two years it might have to be refreshed again. The method must be tested in the calmest way possible, and he proposed to bring forward his cases for his own and the Society's inspection.

SUPPURATION OF THE LEFT FRONTAL AND THE LEFT MAXILLARY SINUSES. CLOSURE OF THE WOUND AND IRRIGATION.

Shown by the PRESIDENT. A man, aged forty, was brought to me in June, 1900, by Dr. Hugh Smith, of Highgate, who had drained the left antrum through the alveolus for empyema. Recovery not taking place, I removed the anterior end of the middle turbinal, and irrigated the frontal sinus, finding it full of pus. Dr. Gregory carried out irrigation of the frontal sinus, and introduced iodoform without effecting a cure. In December the frontal sinus was opened above the left brow, the lining membrane was entirely removed, the opening into the nasal cavity enlarged, the middle turbinal was next removed, the antrum was opened through the incisor fossa and an opening made from the cavity into the inferior meatus, a part of the inferior turbinal being removed. The frontal sinus was irrigated daily, and primary union took place. The nasal suppuration had been of eight years' duration, and no recurrence had followed the operation. He was shown chiefly to indicate the small amount of scar and the success of the method adopted. Mr. Symonds referred to this method as

superior to that of packing or the use of drainage-tubes in the nose and said that it was the plan he usually adopted. He had found some years ago that drainage was unsatisfactory by rubber tubes, and that packing led to infection of the skin and recurrence of suppuration. It was also pointed out that the anterior wall was not completely removed, but only sufficiently to give free access to every part of the cavity, and to enable a free opening into the nose to be made.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ONE HUNDRED AND FOURTH ORDINARY MEETING, *March 2, 1906.*

P. WATSON WILLIAMS, M.D., Vice-President, in the Chair.

HENRY J. DAVIS, M.B.
W. JOBSON HORNE, M.D. } Secretaries.

Present—28 members and 1 visitor.

The minutes of the previous meeting were read and confirmed.

NOMINATION OF ORDINARY MEMBER.

E. TAIT ROBINSON, M.D., M.Ch., R.U.I.,

was nominated for election as an Ordinary Member at the next meeting of the Society.

The following communications were made :

CASE OF TUBERCULOUS LARYNGITIS REMOVAL OF EPIGLOTTIS ; CURE.

Shown by Mr. HAROLD BARWELL. A. G—, a girl aged twenty-one, first seen by me in July, 1905, had had extensive disease of the left upper lobe six years before, and later the right lung became involved. On admission there was impaired resonance at the right apex, back and front, with crepitations and increased vocal resonance; on the left side there were moist sounds behind and in front down to the mid-scapular level, high-pitched dulness, increased vocal resonance, and, near the left side of the spine, whispered pectoriloquy. There was then no expectoration, but tubercle bacilli had been found in January, 1904, and again when, after the larynx had healed, she went to the sanatorium at Northwood. She had been hoarse for five weeks and had suffered for three weeks from

dysphagia, which had become so severe that she had been unable to swallow solids for some days. The epiglottis was much infiltrated and ulcerated on its laryngeal surface ; the remainder of the larynx was unaffected. The epiglottis was removed with punch-forceps in two pieces ; the dysphagia was at once relieved, and the wound healed rapidly. The larynx remains well over six months after the operation, and the general health has much improved.

CASE OF TUBERCULOUS LARYNGITIS ; ACTIVE LOCAL TREATMENT ; CURE.

Shown by Mr. HAROLD BARWELL. The patient, a woman aged thirty, was admitted to Mount Vernon Hospital, Hampstead, in May, 1905 ; she had suffered from weakness of voice and cough for fifteen months, and there were occasional streaks of blood in the sputum, in which tubercle bacilli were also found. Diminished resonance and moist crepitations over the left upper lobe in front and behind. The right arytenoid was congested and swollen, the right cord was reddened, and there was interarytenoid swelling ; the left arytenoid was also slightly swollen. Daily frictions were employed, with a mixture of lactic acid, formalin, and carbolic acid, and a week later a piece of the right arytenoid was clipped away with Lake's forceps. The frictions were continued and the larynx became completely healed. The patient stayed at the Northwood Sanatorium from July 7 to August 9. She is now in service ; the scar of the operation is just visible, but otherwise the larynx appears normal.

Mr. E. B. WAGGETT congratulated Mr. Barwell heartily on his excellent result, particularly in respect to the epiglottis case, which seemed to be absolutely cured. His experience was that tuberculosis of the epiglottis was very apt to resist the good influence of sanatorium treatment, and amputation of it, which had been done a number of times, was, he believed, a very valuable therapeutic proceeding. Some patients refused to submit to the operation under cocaine. A few days ago he had amputated the epiglottis under chloroform anaesthesia, the patient sitting in a chair. Adrenalin and cocaine were employed in addition. No difficulty whatever was experienced in keeping blood from passing the glottis and there were no disturbing symptoms either at or after the operation. As was the usual experience, there was no difficulty in swallowing a semi-solid meal a few hours later.

Dr. H. J. DAVIS asked whether there was any passage of food down the larynx after the operation.

Dr. F. H. WESTMACOTT agreed that the result was very good, and the cases were almost exactly similar to one he had in the previous week, and in which there had been no comfort in swallowing for three months. He did the operation under cocaine, and afterwards painted the part with a solution of iodoform benzoine, and ether. That seemed to take away

the soreness, and was based upon the example of Whitehead in excision of the tongue. The operation was done at 11 a.m., and by 3 p.m. the patient swallowed a cup of tea straight off, which he had not been able to do for months. There had been no cough, and no liquid had got into his larynx since the operation. It was now perfectly healed, and the patient was rapidly gaining flesh. Curiously, he could not take milk, as it seemed to clog around the glottis and some went into the larynx, causing coughing for some time afterwards. Koumis was given, and now he could take a glass of milk with comfort.

Dr. WATSON WILLIAMS congratulated Mr. Barwell on his excellent results. He was beginning to feel, however, that greater results could be obtained from rest and sanatorium methods in laryngeal tuberculosis than was formerly suspected, and recently he had had several cases which cleared up in a way he would not at one time have thought possible without operative treatment. He thought care should be taken to differentiate those which could be cleared up without pain and fairly rapidly under sanatoria methods, from those requiring operation. At present the profession was in a tentative position on the matter. He was not surprised that the loss of the epiglottis had not influenced the patient's comfort in deglutition. He would be a little timid in operating on such a case under chloroform, but apparently it could be done if one had at hand means of treatment should blood get into the larynx. In reply to Mr. Waggett, he said the sanatorium-treated cases were not essentially epiglottis cases, but the epiglottis was involved.

Dr. JOBSON HORNE asked Mr. Barwell for further information about the nature of the lesion of the epiglottis. It was so unusual in Dr Horne's experience of tuberculosis to find the epiglottis typically turban-shaped and no other part of the larynx affected by the disease, that he desired to see a microscopic section cut through the portion of the epiglottis that had been removed. If such a section revealed histological evidence of tubercle, then the case from the standpoint of morbid anatomy was exceptional. From the standpoint of the so-called surgical treatment of laryngeal tuberculosis, it was commonly accepted that the removal of the epiglottis at times afforded relief, and as a palliative measure had been successful. Several similar cases had been recorded in which the physical difficulty produced by disease had been overcome by mechanical means, and not only in tuberculosis; Dr. Furniss Potter¹ had removed the epiglottis as a palliative measure in a case of inoperable malignant disease of the larynx, and with considerable benefit to the patient. One must not, however, regard these palliative measures as remedial, and Dr. Horne agreed with the President that more importance should be attributed to the sanatorium methods as effecting a cure of laryngeal tuberculosis.

Mr. BARWELL, in reply, said the specimen was exhibited in the room with the patient, and Dr. Horne could have a section at any time. The epiglottis was typically turban-shaped, of large size, and ulcerated on the laryngeal surface. Both lungs were affected, and bacilli had been found in the sputum. He believed that of all parts of the larynx the epiglottis was least amenable to treatment by surgery. It was rare to get such a case as the present, where the epiglottis was the only part affected, but in such a case, if removal were done early, the case would do well. The only other case of the kind he knew was Mr. Lake's, in which the epiglottis was the only part markedly affected. It was recorded in the second edition of his book. Indiscriminate operation in tuberculous

¹ *Vide Journ. of Laryngol., Rhinol., and Otol.*, vol. xvii, p. 681.

laryngitis was liable to bring it into disrepute ; prior to any operation the temperature and general condition should be watched. Where there was dysphagia surgical treatment was best. He had never used general anaesthesia for the purpose ; he had done a dozen cases under cocaine, and it was quickly over, and caused little disturbance to the patient. He had never known food enter the larynx afterwards, except once, and then it occurred three months after, and was associated with fixation of the arytenoids in wide abduction.

CASE OF ULCERATION OF EPIGLOTTIS.

Shown by Mr. HAROLD BARWELL. The patient, a man aged forty, came to my Out-Patient Department in July, 1905 ; he had suffered from hoarseness and slight cough for two years ; there was thick yellow expectoration, with, ten days before, a streak of blood. He had been treated elsewhere since February by laryngeal injections of creosote with some improvement. The voice was peculiarly high-pitched ; there was no dysphagia whatever. Fauces and nose normal. Larynx, cords slightly reddened, especially the left ; left band swollen, arytenoids and interarytenoid region normal, firm pink swelling of the epiglottis with serpiginous ulceration giving rise to a peculiar nodular, worm-eaten appearance. The physician reported "a few dry crepitations at the left apex, nothing active." The length of the history, the freedom from dysphagia, the worm-eaten aspect of the epiglottis, with the absence of massive infiltration, did not appear to me typical of tuberculosis. I gave potassium iodide and the voice much improved and the epiglottis appeared to be cicatrising, but he ceased to attend after four weeks. He reappeared on February 22, 1905 ; the voice is good, but there had been slight dysphagia for three weeks : there is further destruction of the epiglottis and slight interarytenoid swelling. I should much value the opinion of the Society on the nature of the lesion.

Dr. H. J. DAVIS thought the condition was lupus.

Dr. WATSON WILLIAMS said his feeling was in favour of chronic tubercle.

Dr. WESTMACOTT asked Mr. Barwell what conclusion he drew from the man's copious rash on the back last September, which rash the patient said sometimes came out now. He had also had, for some weeks, profuse nasal discharge. Since three weeks ago there had been pain and dysphagia. The ulceration seemed to be either tubercular or lupoid. There was thickening of the deep cervical glands on each side of the larynx, which seemed to put lupoid condition out of court. He thought it was tubercular, and asked whether tubercle bacilli were found in the sputum or in the scrapings from the epiglottis.

Mr. BARWELL replied that the sputum had not been examined, as the

patient had been in a large out-patient department, and there had been no opportunity, but the physician reported a few dry crepitations at the apex of one lung. He first saw the patient in July, before he had the rash, and the larynx was in almost the same condition as now. He denied syphilis. The iodide of potassium which he was given might account for his rash. He lost sight of the patient for a long time. His own opinion now was that it was lupus. In reply to Mr. Fox as to why tuberculin had not been used, there had not been an opportunity to take the man into hospital.

A CASE OF ATROPHIC RHINITIS.

Shown by Dr. H. J. DAVIS. Woman, aged 18; atrophic rhinitis; no crusts; posterior wall of naso-pharynx and posterior border of septum plainly visible through each nostril. The naso-pharynx is seen to be moist and lubricated, the oro-pharynx dry and glazed.

Dr. H. J. DAVIS said he really showed the patient more as a curiosity. She came to the hospital complaining of dyspepsia and dryness of the throat. He did not think that he had ever seen a case in which the naso-pharynx was so plainly visible through the anterior nares, nor one in which the posterior border of the septum and the Eustachian tubes were also visible through the nose. He asked why it was that the naso-pharynx was well lubricated and moist and the other part of the pharynx dry. He thought that in atrophic rhinitis there was dryness of the upper part of the naso-pharynx as well as dryness in the lower; but the back of the oro-pharynx in this case had always remained dry and glazed, and nothing that he had done for the patient had brought relief of this symptom of which she complained. He invited opinions as to the cause of the dryness in the oro-pharynx alone, and suggestions with regard to treatment.

Dr. H. SMURTHWAITE said he had a patient at present with atrophic rhinitis, which was certainly as marked. One could see the Eustachian tubes, and towards the frontal sinus, the middle and inferior turbinals, being much atrophied. He complained of the rush of cold air when cycling. He had decided to give him a false turbinal by injecting under the atrophied membrane cold paraffin.

Dr. WATSON WILLIAMS thought it was an open question how far the dryness of the membrane was due to the pathological condition underlying the affection and how far to the simple absence of ordinary moistening of the membrane. He did not think the laryngeal complications were merely due to nasal conditions, but to direct implication of the larynx.

Mr. CHARLES PARKER thought the middle turbinates were much enlarged, and that the dryness was due to the diversion of the air from its usual course through the superior meatus and over the vault of the naso-pharynx. He thought the oro-pharynx would be found dry instead of the naso-pharynx in many cases of marked enlargement of the middle turbinates.

RECENT PHOTOGRAPHS OF SOME CASES OF PARAFFIN INJECTION FOR
NASAL DEFORMITY, AS WELL AS OTHERS TAKEN IMMEDIATELY AFTER
TREATMENT FOUR YEARS AGO.

Shown by Dr. WALKER DOWNIE. The subject of the removal of deformities of the nose by the subcutaneous injection of paraffin was discussed at the last meeting. I learned of this from a member of this Society by letter, but did not know the lines of the discussion until I received my billet yesterday, just as I was leaving Glasgow for London.

All, apparently, are agreed that in many cases a deformed nose can be made more shapely by the judicious and careful introduction of paraffin, and that this can be done with safety.

The point at issue is as to the permanence of that improvement. Some hold that the injected paraffin becomes absorbed, or that it slowly disappears and the deformity recurs, others that it somehow disappears and is replaced by fibrous tissue.

Since receiving the letter referred to I had photographs taken of some of the cases operated upon by me four years ago, and they are shown to-day. If they be examined it will be found—

(1) That the *shape* of the nose is practically identical with the photographs taken within two weeks of the operation, showing that the deformity does not necessarily recur.

(2) In those cases the injected paraffin can be felt as a well-defined firm mass, occupying the same site as it did immediately after injection, and this mass can be readily caught up between the finger and thumb.

I do not believe that the paraffin becomes absorbed—it certainly has not done so in any of my cases, for I have still the majority under observation, and there are two reasons for this belief: (1) The character of this mass when examined with the fingers is the same four years after injection as it was two weeks after operation; (2) from my experience of the removal of paraffin months and years after injection.

In one case where the injection had been given in Manchester, and where the quantity introduced had been excessive, I removed a quantity of the paraffin three years later. In one operated on in London I removed the paraffin two years after operation, and in another operated on in a London hospital I removed paraffin from the forehead six months after the injection. In each case the paraffin was found to be present, and to be in a fine state of division, in small rounded particles, separated by bands of tissue.

The finding of the paraffin in small particles is not to my mind the early stage of absorption, for this division takes place at the time of injection, if molten paraffin be used, as I showed by the experimental injection of paraffin into a mamma one week before its removal. The conditions found on examination afterwards were reported by me at a meeting of the British Medical Association in 1902. In that communication I reported: "In section the paraffin appears almost entirely in the deeper parts of the subcutaneous fat. It is distributed throughout this layer in blocks of varying size, the largest being perhaps about the size of a pea. These masses, which are either distinctly lobulated, or more irregular, with rounded processes, occupy in every case a position between collections of adipose vesicles which are displaced by them. It is inferred that the paraffin has made its way along the lines of connective-tissue trabeculæ between fat-containing cells." And I further expressed this opinion: "From the fact that the infiltration of the paraffin is definite and tolerably intimate it is difficult to believe that its position would subsequently alter to any extent, although its absorption is possible."

The paraffin breaks up on its introduction; it runs along the cellular planes, and is not eaten into later by the living tissues. And it is held in position by the trabeculæ of the minute planes of cellular tissue in the same way as the fat of adipose tissue is kept in place. I must also say that I have never seen migration or wandering of the paraffin after it has once set. Whilst being injected it, of course, follows the line of least resistance, but after it has set I have never seen it wander beyond the confines of the nose.

In those cases where paraffin has been found in other parts of the face I fear it has reached those regions while the injection was being given and while the paraffin was still in a fluid state.

I can understand, however, the wandering of paraffin introduced in the solid state, as this can never become so intimately incorporated with the tissues as when molten paraffin is introduced.

The paraffin which I still employ has a melting point of 106°-108° F. I still use the electric current to heat the needle, as described by me in the *British Medical Journal*, November, 1902, by the use of which I am able to keep the paraffin in a fluid state as it enters and passes through the needle, and by which contrivance the temperature can be so easily regulated that there is no risk of scalding the skin, which some operators fear and others report as having occurred, and I never now employ either a local

or a general anaesthetic. I have now operated upon close on 140 cases, all with very definite deformity, and in most cases with a very satisfactory result, and until I am convinced, by experience, of its futility or danger Dr. Kirschner's theoretical objections, quoted at last meeting by Sir Felix Semon, will not prevent me from giving to those who desire it the benefit to be derived from this operation.

Dr. WATSON WILLIAMS congratulated Dr. Downie on the results he had obtained over a long course of observations in such cases. He was much struck by the really cosmetic results. Some of the cases had been treated four years previously.

Mr. STEPHEN PAGET added his congratulations. He regretted he was not at the last meeting, and had wondered at the dictum then quoted from a German doctor, who said that the paraffin must either remain like a bullet or must vanish. As a fact, the paraffin did not vanish. There were many cases where one wished it would, where it had to be dissected out because it had gone astray. Much of the vague talk on the subject was due either to the fact that operators did not pick and choose their cases, or that they did not pick and choose their paraffin. A case could not be done justice to unless there were loose, healthy skin. It would be a good thing to collect cases years after injection. A few days ago he saw the first case he did three and a half years ago, and the paraffin had not stirred. He then used it of 125° melting point, but now used it at 115° . Most of the misfortunes which occurred were due to having paraffin with a low melting point or to excess of paraffin. It was unfair that a method so useful for bad cases of deformity should have undeserved blame attached to it. No one should use it simply to minister to a person's vanity.

Mr. CHARLES PARKER asked Dr. Walker Downie if, in his experience, injections of cold paraffin were more likely to shift afterwards than those of melted paraffin, and whether there were any dangers connected with its use for increasing the size of the inferior turbinals in cases of atrophic pleuritis. Cold paraffin used by means of Mahu's injector was such a simple method that if there were no dangers attached to it, and if the results were permanent, he would be tempted to employ it.

Dr. SCANES SPICER said the results as shown in the photographs were the best he had seen; one lady had a most beautiful Roman nose. The great objection to the method was the difficulty of carrying it out without scalding and suppuration, in spite of local antiseptic precautions. He had had six or seven cases—all among hospital out-patients—but had not followed them up since they ceased attendance. He would try to ascertain the ultimate result in some of them. In one advanced syphilitic case there was plenty of loose skin on the nose, but the nasal cavities were very foul indeed. The sites of injection suppurred freely and repeatedly, and the patient in the end was no better. He always sealed his cases with a wad of cotton-wool dipped in collodion.

Dr. SMURTHWAITE asked whether the cold paraffin was likely to move after the operation. He produced a beautiful nose the other day by this method, but if it was not going to last more than nine months he would rather not have done it.

Mr. P. DE SANTI said the only two cases he had done were complicated by considerable adhesions, due to necrosed and carious nasal bones. He

found that by a proper subcutaneous dissection of the parts underneath and loosening the tissues the paraffin could be injected satisfactorily. He did not think the adhesions were an insuperable objection to injection.

In reply to questions, Dr. WALKER DOWNE said that he showed these photographs to prove that the removal of nasal deformities by this method was practically permanent. He agreed with Mr. Stephen Paget that when the skin was loose and healthy the operation was a comparatively easy one and the result satisfactory. When the skin is bound down by adhesions to the underlying bone, then the injection must be preceded by the subcutaneous division of those adhesions, and as soon as the bleeding has been checked by pressure this should be followed by the injection of the paraffin. Dr. Walker Downie had not employed paraffin in the cold state, and so had no experience on which to base an opinion. But he had the feeling that it cannot, injected in this form, become so intimately incorporated with the tissues as paraffin which is inserted while in a molten state. Its shape would, he thought, be readily altered by trifling blows or firm pressure, injuries which would have no effect on the solidified paraffin which had been injected in the molten state. Scalding of the parts spoken of by Mr. Scanes Spicer might readily be prevented by the use of his device of keeping the needle warm by means of the electric current, which is always fully under control and may be regulated at will, and by avoiding the use of paraffins having a melting-point of over 110° F. He thanked the members of the Society for their kind reception of his communication.

DESCRIPTION OF TWO CASES WHERE OESOPHAGOTOMY WAS PERFORMED FOR THE REMOVAL OF A DENTURE IMPACTED IN THE GULLET.

Reported by Dr. WALKER DOWNE. These two operations were performed during the past nine months, and both patients were men, one aged fifty-two and the other thirty-four. In both cases the tooth-plate passed from the mouth into the gullet while the patient was asleep. In both the body was readily caught by the coin-catcher, but in neither case could it be removed. Kilian's oesophagoscope was used in the first case, but it did not reveal the presence of the foreign body, on account, I think, of swelling of the gullet wall, for many attempts to remove the body had been made before he came to the Western Infirmary, Glasgow. The oesophagoscope was not used in the second case, as the patient had emphysema of the neck and immediate operation was imperative.

In the first case the denture had, by pressure, caused necrosis of a small area of the gullet wall.

In each case the incision was made on the left side of the neck in line with the anterior border of the sterno-mastoid muscle, and after removal of the foreign body the gullet wall was not stitched and the wound was lightly packed and allowed to granulate. The

safety of this method cannot be over-estimated. A rubber tube was passed through the nose into the stomach, by which the patient was fed, and this tube was retained in one case for three and in the other for four days.

In each case the wound healed satisfactorily and completely without any complications, and in the second case the man was back to his work as a *chef* on the twentieth day after operation.

SKETCH OF LARYNX AND MICROSCOPIC SECTION OF UVULA FROM CASE OF HYPERPLASTIC CONGENITAL SYPHILIS.

Shown by Dr. A. BROWN KELLY. This was the case of a boy who suffered from stridulous breathing. Examination showed that laryngeal stenosis was caused by immense enlargement of the arytenoids, which formed two smooth, rounded, symmetrical masses. The soft palate and uvula also presented thickening of a similar character.

There was an undoubted history but no signs of congenital syphilis. Specific treatment reduced the infiltrations only slightly, and the sketch of the larynx shown represents its permanent aspect.

The case is one of a small class first described by Sir Felix Semon, and is of interest because of the uniform and symmetrical character of the infiltration, the absence of ulceration, the resistance to specific treatment, and the tendency to acute laryngeal oedema and suffocation.

CASE OF FIBRO-ANGIOMA OF NASAL SEPTUM.

Shown by Mr. H. BETHAM ROBINSON. The male patient from whom I removed this growth came under my care in March, 1904. He was a robust man, aged fifty-eight, and stated that about the previous Christmas he had knocked his nose with a cane. There seems to have been no inconvenience at the time, but a fortnight after he noticed some fulness of the nose. His only complaint afterwards was progressiveness of the left nostril and epistaxis on two occasions. Examination showed a soft granulomatous-looking growth practically filling all the lower part of the cavity in front and touching the outer wall; behind it reached a short distance between the front of the middle turbinate and septum. Its base of attachment to the septum was half an inch long in an horizontal

direction in front and involving the tuberculum. It was extremely vascular. I removed it with a snare and touched the base with a cautery point. The growth on section had a very fleshy look, "like a sarcoma," but it seemed possibly in the main to be partially organised blood-clot. Histologically, it consists of a very vascular fibrous tissue, the blood-spaces varying considerably in size and some of them containing clot. The margin is more cellular, like granulation-tissue, and at one or two spots there is organising blood-clot to be seen. There has been no recurrence of the tumour.

Dr. PEGLER said the most conspicuous feature of the specimen was the enormous size of its angiomatic spaces, which were larger than in any other of the seventeen examples in the possession of the Society. The history pointed in favour of a granulomatous character for this growth, and its histological structure was not greatly opposed to it; indeed, a careful study of granulation-tissue in its various forms showed that that tissue foreshadowed almost every variety of bleeding polypus, and, therefore, inclined the speaker more and more to the belief that they were all varieties of granuloma. Dr. Betham Robinson's specimen did not differ essentially from Dr. Kelson's exhibited to-day. The plasma layer replaced the squamous epithelium almost completely, the granulation-tissue zone was least conspicuous, and the central body of fibrous and fibro-angiomatic tissue predominated.

A PATIENT SHOWN IN JUNE, 1905, WITH THICKENING OF RIGHT CORD,
THOUGHT TO BE MALIGNANT; EXHIBITED AGAIN FOR FURTHER
DIAGNOSIS.

Shown by Dr. SMURTHWAITE. The patient is a man aged fifty-eight, whom I brought before the Society in June of last year, suffering from a progressive loss of voice and cough of two years' duration. When he first consulted me the following was the laryngeal condition: The right cord was uniformly thickened, and at the junction of its posterior and middle thirds there was a small growth about the size of a pea. In addition the false cord was diffusely infiltrated, or rather had the appearance of a general thickening and irregularity of the membrane. There was no fixation of the joint, but the cords could not be properly approximated on account of the small growth above mentioned. There was general redness in the interior of the larynx.

I removed the growth and submitted the same to a pathologist, who pronounced it to be a squamous epithelioma. Some three weeks later the patient was shown to the members of the Society, and some half-dozen kindly examined him, and later expressed

the opinion that the laryngeal trouble was undoubtedly malignant, and advised that a laryngo-fissure be undertaken and the growth be thoroughly removed. This procedure I determined to carry out, but the patient's voice and the general appearance of the larynx improved so much that I put off and have not felt justified in carrying out a more or less radical operation.

The patient is here again to-day, some nine months later, and I should be very glad if those same members would again examine him and say if they still hold to the diagnosis.

Mr. DE SANTI said he was one of those who examined the case a year ago, and then the appearance was such that he thought it malignant. There was now no sign whatever of malignancy.

Dr. STCLAIR THOMSON said he was another of those who were mistaken over this case, but he did so in good company, because one of those who were strongest in regarding it as malignant was Sir Felix Semon. He admitted there was no fixation of the vocal cord. But this case raised the question whether possibly vocal cords had sometimes been removed under the impression that they were malignant, when perhaps they were not so. Dr. Smurthwaite had the report of a trustworthy pathologist in the north that the growth was malignant; this was confirmed clinically by members of the Society; and if the case had been operated on it would have been recorded as a case of cure of malignant disease of the larynx. The Morbid Growths Committee of the Society reported that it was not malignant, and the whole condition seemed to be clearing up. It made even members of the Laryngological Society of London a little humble.

Mr. WAGGETT said this case could not be quoted as one telling against the value of histological pathology, for the Morbid Growths Committee, on examining the specimen, which had been previously reported upon elsewhere, had no hesitation in saying that they could see nothing in the least suggestive of malignant disease.

Dr. PEGLER said that two or three years ago a case was exciting interest, and was reported upon as papilloma, but further investigation led to the belief that it might be regarded as a carcinomatous condition. The pathologist regarded it as papilloma. It showed how careful one should be in reporting. In Dr. Smurthwaite's case the Morbid Growths Committee only reported that it was not any malignant disease of epithelium.

Dr. WATSON WILLIAMS expressed the Society's indebtedness to Dr. Smurthwaite for bringing the case forward again.

Dr. SMURTHWAITE, in reply, said that two weeks before bringing the case up he had naturally made a big wound on the right cord in removing the growth, and there was much inflammatory thickening round the base. Thus it showed an ulcer, and knowing of the report of the pathologist that it was squamous epithelioma, members would incline to that diagnosis. Had they seen the larynx before the small growth was removed their opinion might have been different. When the man was first brought to him he gave a guarded diagnosis, saying that the thickening of the false cord and the growth gave a suspicion of malignancy, but a point against that was the small amount of fixation of the cord. The chief symptom was coughing, which had existed two years, but since the removal of the growth had entirely disappeared, and the patient was now perfectly well.

CASE OF SECONDARY SYPHILITIC LESIONS OF THE VOCAL CORDS IN A
GIRL AGED TWENTY.

Shown by Dr. PEGLER. The patient contracted syphilis in a northern town about a week before Christmas, 1905, and had only been under observation for ten days. She had abundance of rash on the body and legs, and mucous patches on the enlarged tonsils and pharyngeal wall. She had consulted Dr. Pegler on account of hoarseness and dysphonia. The vocal cords were red, and showed yellowish patches of ulceration; their borders were eroded, all more marked on the right. There seemed good reason to believe that the condition represented a phase of mucous patches on the cords.

A BOY, AGED SEVENTEEN, WITH ABSENCE OF RIGHT CHOANA.

Shown by Mr. WAGGETT.

Dr. STCLAIR THOMSON thought such cases worthy of some attention, as they showed a certain fallacy in accepting experimental results from the physiological laboratory. The experiment of Ziem relating to the nasal cavities of puppies was, perhaps, the most quoted of any experiment in the literature of laryngology—*i. e.* that sewing up one side of the nose prevented that side of the face from developing. He (Dr. Thomson) could bring forward a young woman, aged nineteen, with a most symmetrical face and an excellent low Norman arch to her palate; but the mother said she had only been able to nurse her, as an infant, at one breast, because on putting her on the other side the only open nostril seemed to block up. This patient always had to wait for the mucus to trickle out of one nostril, and then wipe it away. That case confirmed Mr. Waggett's point, *i. e.*, that there was perfect symmetry between one side and the other, and both those cases from Nature were opposed to Ziem's experiment. He operated upon his case, and she had a half-membranous, half-bony obstruction, quite complete, as he was able to feel in the post-nasal space. He broke it through and nipped a good piece out of the vomer; he had examined the case ten months later, and there was no recurrence.

Dr. H. J. DAVIS said that in the experiment with the puppy mentioned by Dr. StClair Thomson, in which the nostril had been obliterated, the obstruction would in this case be in the anterior part of the nose, but in Mr. Waggett's case the nose was obstructed a long way back, and this might probably account for the different results.

Dr. SCANES SPICER thought the Society should feel indebted to Mr. Waggett for bringing this case forward. It was one of the most interesting the Society had ever had, for it afforded the opportunity of testing the interdependence of arrested functional activity and growth. He had not yet satisfied himself that it was a case of congenital bony occlusion, for he had not been able to see very well, or to interpret the masses which he had dimly seen. He thought he saw a small foramen just below the superior fornix on the right side, as if that choana

were not occluded completely by bone. Several points suggested that the face here was not symmetrical. There was alternating internal strabismus, not infrequently seen in cases of nasal obstruction, and which one sometimes found to disappear entirely after clearing the obstruction. He believed also that the eyes would be found to be astigmatic. The patient's palate was very high. Dr. StClair Thomson's case of posterior occlusion was a different matter from getting obstruction in the front of the nose. Zeim's experiments were done with the nasal channels blocked anteriorly or throughout, and other factors than the obstruction assisted in the results he got, such as the muscular activity of alæ and the inflammation which had occurred. The case was deserving of full examination and consideration, even to the extent of devoting a whole evening to it, and most members would no doubt look up previous work bearing on the subject.

Dr. WATSON WILLIAMS thought it would be well to ask Mr. Waggett to bring the case again to the next meeting, and he could defer his reply till then.

CASE OF SWELLING PROJECTING FROM LEFT TONSIL (RETENTION CYST)
IN A GIRL AGED TWENTY-THREE.

Shown by Dr. FURNISS POTTER. No symptoms were complained of. A swelling was to be seen protruding from the left tonsil about the size of a horse-bean. The surface was of a pale yellowish grey colour, and examination with a probe gave the impression of fluid. Two similar conditions were observed on the right tonsil, but much smaller in size. The diagnosis was confirmed by incision of one of these latter, which resulted in the extrusion of a small quantity of tenacious secretion and collapse of the swelling.

MICROSCOPIC SECTION FROM A CASE OF NASAL ANGEIOMA (BLEEDING POLYPUS) REMOVED FROM THE FLOOR OF THE INFERIOR MEATUS
IN A GIRL AGED FIFTEEN, BY Dr. KELSON.

Shown by Dr. PEGLER. The patient was shown by Dr. W. H. Kelson in March, 1903, but there was some error in the report of the case, which was confused with the preceding one. No section was exhibited. This slide had been kindly handed over to the Society by Dr. Kelson. It displayed very clearly the three zones so commonly seen in discrete nasal angeioma where the stratified epithelium has disappeared—viz. (1) a plasmatic layer; (2) a granulomatous or lymphocytic zone; (3) a trabecular fibro-angeiomatous meshwork constituting the body of the growth in which the endothelioid cells come into prominence and the lymphocytes diminish. Though growing from the floor of the nose, this specimen was almost identical in character with that shown by Dr.

Scanes Spicer in December, 1897, removed from the triangular cartilage, showing how little value attached to a grouping of these bodies based upon site of growth apart from pathology.

A WOMAN WITH IMMOBILE RIGHT VOCAL CORD; PREVIOUSLY SHOWN
MAY 5, 1905.

Shown by Mr. de Santi. The patient was brought before the Society after the lapse of ten months to show that the condition of the larynx was unaltered. When exhibited in May, 1905, considerable diversity of opinion was expressed as to the diagnosis. Dr. Scanes Spicer had suggested aneurysm, but a radiograph showed nothing abnormal. Sir Felix Semon had been doubtful as to the question of paralysis or mechanical fixation, and had suggested possible congenital ankylosis of right crico-arytenoid joint. Dr. Dundas Grant had suggested epithelioma, and Dr. Horne a tubercular origin. Mr. Barwell considered the condition to be one of fixation.

Since May the patient had been under iodide of potassium, and had lost all cough, hoarseness, and pain, and expressed herself as being in much better health generally. The condition of the larynx was, however, exactly the same as when first seen. Mr. de Santi considered the case one of mechanical fixation; whether of congenital, specific, or rheumatic origin it was difficult to say.

Mr. Waggett thought it was a case of articular fixation, and not paralysis, and Dr. Davis agreed.

Dr. Watson Williams said he took the same view as Mr. Waggett from the position of the fixed arytenoid, which was suggestive of some implication of the joint.

PROCEEDINGS
OF THE
LARYNGOLOGICAL SOCIETY OF LONDON.

ONE HUNDRED AND FIFTH ORDINARY MEETING, April 6, 1906.

CHARLES J. SYMONDS, F.R.C.S., President, in the Chair.

HENRY J. DAVIS, M.B. }
W. JOBSON HORNE, M.D. } Secretaries.

Present—26 members and 1 visitor.

The minutes of the previous meeting were read and confirmed.

The ballot was taken for E. TAIT ROBINSON, M.D., M.Ch., R.U.I., who was elected a Member of the Society.

The following communications were made :

A CASE OF SUDDEN LOSS OF VOICE.

Shown by Dr. H. J. DAVIS. The patient, a man aged forty-three, had had sudden loss of voice fourteen days previously, following "a cold"; the cords were subacutely congested, the left cord was fixed. The case was shown for diagnosis.

Dr. Davis said he thought the man had had his cord fixed for some time, and on this had supervened an attack of acute or subacute laryngitis. It was probably a coincidence. He did not know of any disease which would produce fixation on one side completely in a fortnight. There seemed to have been no loss of voice previously. The chest showed no signs of aneurysm or tubercle, though the patient said he was getting thinner. He had been in the Army in India. There was scarcely any sputum to examine for bacilli.

Mr. CRESSWELL BABER said there was a good deal of swelling of the left ventricular band as well as want of movement in that cord. He could not say what the nature of the case was. It might be either syphilitic or tubercular.

Mr. ATWOOD THORNE pointed out that the patient gave a history of fracture of the base of the skull two years ago.

Dr. DUNDAS GRANT thought the case was well described as fixation of the left cord rather than paralysis. He believed the fixation was due to a mechanical local process. Like other speakers, he did not think the fixation was likely to have come on in the short time specified in any other form than as an acute arthritis of the joint, which would almost certainly have been accompanied by pain. It was very probably due to old specific trouble, and the present sudden loss of voice was attributable to laryngitis following a "cold."

Dr. STCLAIR THOMSON thought the diagnosis could be narrowed down to specific disease or tubercle. The man stated that he had lost two stones in weight, which was a considerable reduction. He (Dr. Thomson) had a suspicion that there was something like ulceration. He agreed as to its being fixation and not paralysis, and that there was diffuse infiltration about the cord. The situation was towards the arytenoids.

The PRESIDENT said the general pallor in the larynx, which was described as "subacutely congested," struck him as supporting the view that the condition was tubercular, especially when taken with the great loss of voice. There was a fair approximation of the cords.

Dr. DAVIS, in reply, said that if the paralysis of the cord on the left side had only come on during the last fortnight coincidently with the laryngitis, there would have been more paresis in the other cord. His opinion was that he had had trouble there for some time. He was still able to talk. The acute laryngitis probably called attention to a condition which had existed for some time.

A CASE OF NASAL OBSTRUCTION.

Shown by Dr. DAVIS. The patient, a man aged sixty-two, complained of nasal obstruction of fourteen weeks' duration on the right side following facial paralysis; the asymmetry in the apertures of the nostrils was still marked. Under the electrical treatment the condition was improving.

Mr. CRESSWELL BABER drew attention to the deflection of the septum; the anterior edge of the cartilaginous septum projected into the right vestibule and helped to produce the obstruction.

Dr. WILLIAM HILL said in his experience such a condition sometimes caused annoyance after facial paralysis in connection with aural disease. A week or two ago he had a patient who had had facial paralysis, but in whom a good deal of movement had returned; he did not worry whether he could quite close his eye, but wanted to breathe through his left nostril. He was recently having electricity twice a day, ten minutes at a sitting; but that did not answer, therefore he put in a celluloid plug, and that cleared up the disability at once. The patient was very much relieved, both in mind and in regard to respiration.

A CASE OF ABSENCE OF THE RIGHT CHOANA.

(Shown at the previous meeting, March 2, 1906.)

Shown by Mr. E. B. WAGGETT. The patient, a boy aged seventeen, had had symptoms, pointing to the absence of the right

choana, dating from infancy. The face was symmetrically developed.

Dr. WILLIAM HILL said he was not sure whether the reference to absence of the right choana was not a terminological inexactness, because he found the patient had got an anterior naris. He believed that in rhinological literature the term "choana" was applied to the whole cavity of the posterior and anterior nares.

Mr. CRESSWELL BABER, in answer to Dr. Hill, said that the term "choana" applied to the posterior aperture of the nasal cavity.

Dr. DONELAN said he had referred to a Greek dictionary, which said that "choana" was equivalent to the Latin "infundibulum." A man who was a great drinker in ancient Greece was called a choana. The term referred to the funnel-shaped space leading to the œsophagus. It was quite incorrect to speak of "posterior choana," though usage allowed "posterior nares."

Dr. SCANES SPICER said Dr. Donelan's rendering of the meaning of the word "choana" was doubtless correct, but in the conventional use of the term in rhinology it signified the opening of the posterior nares.

Mr. WAGGETT explained that he brought the case because he thought the condition rare. The boy had never had any breathing space through his right nose, which was quite normal and well developed, except that there was no posterior orifice, the choana being blocked by a bony wall. There seemed to be almost perfect symmetry of the face, and the palate was not very ill formed, for the reason, he took it, that breathing had been very adequately conducted through the left nose, which was large. The boy had not suffered from the effects of nasal obstruction. He was aware that there were adenoids and catarrh present. Three months ago he came with subacute otitis media on both sides.

Dr. DUNDAS GRANT reminded members that he once brought forward a case (December 13, 1893) with obstruction of one posterior choana and with asymmetry of the face, but the atrophy was on the opposite side to the obstruction. Shortly afterwards Mr. Baber showed a similar case.

Dr. H. PEGLER asked whether the cases shown by Dr. Grant and Mr. Baber some time ago were not cases of web-like formations.

Dr. GRANT replied that in his case there was a web-like formation, but the obstruction was complete.

Mr. CRESSWELL BABER, in reply to Dr. Pegler, said he showed his case in 1893. The patient was a boy aged six, and his right choana was completely obstructed, the obstruction being partly membranous and partly bony. The right cheek, the affected side, was more prominent than the left.

Dr. LAMBERT LACK said that the great interest of this case was that the teeth were equally irregular on both sides, the palate was high equally on both sides, and the face was as symmetrical as that of most people, although the nasal obstruction was entirely unilateral. These facts had an important bearing on the etiology of these deformities of the palate and teeth. If, as he maintained, the deformity was the direct result of the increased tension of the soft tissues of the cheeks, which in turn resulted from keeping the mouth open, it did not matter which side of the nose was blocked provided that the nasal passages were insufficient and the patient was compelled to keep the mouth open. The effect of the open mouth was then bound to be symmetrical deformity, as in a case

which he had shown at that Society the patient had one side of his face paralysed for many years. In this case the deformity was unilateral, because the paralysed side of the cheek was flaccid, and consequently could exert no increased pressure. These two cases taken together were the strongest proofs in favour of the theories which he (the speaker) had always supported.

Dr. SCANES SPICER said it was important to decide the fact whether there was facial asymmetry or not. Last time he saw the case he thought there was not, but subsequent inspection under different illumination led him to think there was. There was a noted Cambridge school of anthropology, and Mr. Waggett would be doing the Society a service if he would have careful anthropometric measurements made. He judged the left side of the face to be decidedly broader than the right. No one dreamed that nasal respiration was the only factor in bringing about the evolution of the face. Ziem, in his elaborate monograph ('Monats. für Ohrenheilk.', Berlin, 1883) mentioned many other momenta; and nasal obstruction on one side would not of itself cause such an enormous difference in the two sides of the face that accurate measurements were superfluous. But assuming the patient's face was symmetrical, each time he had examined the boy he found the left side blocked as much as the right, practically a bilateral stenosis. The same thing had been noticed in Žaufal's case (quoted by Ziem in his monograph), that of a girl aged seventeen, who had bony obstruction on one side and catarrhal obstruction on the other, so that the nose was practically entirely blocked. The eyes also should be examined, as he believed there would be found a considerable difference in the shape of the eyeballs on the two sides and astigmatism. There seemed also to be too much sclerotic showing. In many ways the lad's physiognomy was unusual and peculiar.

The PRESIDENT said some years ago he had a couple of cases of unilateral and one of bilateral congenital atresia of the choanae, and in the unilateral cases certainly there was no asymmetry. Both were relieved by operation. In those cases on which he had operated he noticed that whereas the two bony margins of the aperture were in close apposition, there was a little membranous material between the two. That was also the case in the patient shown by Mr. Cresswell Baber. He doubted whether there was any real bony fusion between the two sides; there was usually a little aperture which could be got through. He understood the boy had adenoids, so that they should be taken into consideration in accounting for the appearance of the face.

Dr. LOGAN TURNER thought the remarks which had been made suggested that the examination as to asymmetry should not be limited to the face but should include the limbs. The 'Edinburgh Medical Journal' of last November contained the record of a very interesting case in which there was asymmetry.

Dr. PEGLER asked whether Mr. Waggett proposed to do anything to open up the atresia.

Dr. H. J. DAVIS agreed with Dr. Scanes Spicer as to the presence of asymmetry in the boy's face. If he were set to draw the face he would make it wider on the left side.

Mr. WAGGETT, in reply, said he had been seeing the boy about three months, during the early part of which he could breathe perfectly through his nose. His adenoids were now becoming troublesome and must be dealt with. He did not yet know whether he would operate upon the nose. There might possibly be slight want of symmetry in the face, but

not more than was seen in a large proportion of normal persons. Some people thought that the development of the facial sinuses was dependent upon the function of respiration. But in this boy the antrum was very well developed, although connected with a nose which had nothing to do with respiration. The speaker could not help looking upon the tongue as the prime factor in determining the formation of the mouth. It was the principal muscular organ of mastication, and with the subsidiary muscles (*e.g.* masseters) moulded the facial skeleton. The plastic influence of that remarkably powerful muscular action was at play throughout the twenty-four hours, under normal circumstances, and where mouth-breathing existed the tongue could no longer mould the palate, and as a consequence the alveolar arch developed no proper lateral expansion, and the narrow (*so-called "high-arched"*) palate resulted. In this boy, thanks to his thoroughly adequate left nose, nasal breathing had been largely practised and the tongue had moulded the palate into very fair form. The palate was symmetrical.

A CASE OF ULCERATION OF THE LEFT CORD.

Dr. KELSON showed a man aged twenty-six suffering from ulceration of the left vocal cord. Patient had been hoarse for three months; he had not lost weight, and no lung changes had been detected, but there was a family history of phthisis. The sputa were very scanty and had not been examined. There was no history of syphilis. The posterior half of the left cord was ulcerated, but it moved well; the right appeared to be normal. No enlarged glands could be felt.

Dr. DUNDAS GRANT thought the case was tuberculous.

Dr. SCANES SPICER thought the case had the red, angry look of a specific ulceration. Moreover it was unilateral.

The **PRESIDENT** asked whether any remedies had been tried.

Dr. KELSON, in reply, said iodide of potassium had been given for two months, and the case appeared now to be exactly where it was before.

Dr. H. J. DAVIS said if the case was tubercular iodide of potassium given for two months would have made the condition worse.

INSTRUMENTS FOR SUBMUCOUS RESECTION OPERATION.

Shown by **Dr. H. SMURTHWAITE**. In rectifying septal deflections by means of the submucous resection operation our two greatest difficulties are (1) the commencing separation of the muco-perichondrium, (2) the cutting through the cartilage previous to separating it from the muco-perichondrium of the opposite side. Within the last two years a number of ingenious instruments have been devised by men working in this field of surgery which have materially helped to simplify and lessen the time of operation. The use of a certain instrument is often a matter of adaptation,

one man being able to do good work with one instrument, whilst another prefers some other shape. With one or two exceptions, such as Killian's plough and Hajek's chisel, I have had the instruments I use for the operation made for me by Mayer and Meltzer to my own design. Two which I have had made for me just recently were designed for overcoming the before-mentioned difficulties. One is a rougine for separating the membrane after making the preliminary vertical incision. I used to find some difficulty in getting properly underneath the perichondrium with the straight smooth-edged elevator, sometimes merely separating the mucous portion of the muco-perichondrium, with a consequent rupture of the same when any force was applied. With this rougine, having a curve, the force can be more readily applied on to the septum and the fibrous portion of the membrane raised. After the part is once raised from the cartilage the curved separator can be used to complete the separation of the membrane. The other instrument I have is a knife for cutting through the cartilage. Its cutting edge is in a line continuous with the long axis of the handle. The instrument can thus be used like a pen, and lends itself to that delicacy of movement so necessary when cutting through the cartilage, desirous as we are of not wounding the opposite muco-perichondrium. The cartilage is cut through obliquely till the blade disappears up to the guard on the handle, the resector is then introduced, and the separation of the necessary amount of cartilage completed.

A CASE OF GLOTTIC STENOSIS.

Shown by Dr. STCLAIR THOMSON. A girl, aged sixteen, with laryngeal stenosis. This case was shown for diagnosis, which rested between functional adductor spasm and bilateral paralysis. It was difficult to apply the usual tests for making her inspire suddenly and deeply, as she was a foreigner, speaking only Russian and Yiddish. It appeared she had been some months in a Russian hospital for the same affection. He was inclined to view the case as one of functional spasm. There was a constant twitching movement of the arytenoids, although the cords did not abduct. When taken into the hospital and watched, the girl slept quietly, and only developed stridor when attention was given her.

Dr. SCANES SPICER thought the case was one of functional tonic adductor spasm, with clonic spasms superadded.

Mr. ATWOOD THORNE said that when he saw the patient she was very

tired, and the right side of the larynx was absolutely fixed. The left side moved a little.

Dr. DUNDAS GRANT wondered whether Dr. Atwood Thorne was certain as to the side, because he (Dr. Grant) found the left side almost immovable, while the right had some movement. Possibly Dr. Thorne and he took different fixed points. He regarded it as an hysterical case. Anæsthesia of the pharynx seemed to be indicated by her extraordinary tolerance of examination. She also had considerable exaggeration of the knee-jerks.

Dr. FITZGERALD POWELL thought the case should be regarded as one of abductor paresis, not total paralysis, as there was evidently some movement in the left cord. He was inclined to think that the condition was due rather to the toxin of diphtheria than to hysteria or the neurotic element. The mother had stated that the girl had been in hospital in Russia one year ago, and that the doctor had told her that her daughter was suffering from diphtheria.

Mr. DE SANTI thought the present case of adductor spasm was very much like one he showed some time ago, and which some members mistook for double abductor paralysis. One member got her to make a prolonged "e," and she then took a deep breath and the cords abducted thoroughly. The nature of the case was eventually settled by putting her under an anæsthetic; her breathing had been so bad that his colleague, Dr. Hall, thought tracheotomy would be necessary. But under the anæsthetic the breathing became perfect. He thought the present patient should be put under an anæsthetic, when he believed she would breathe all right.

Dr. SMURTHWAITE said the patient gave a history of it having come on all at once, and that was in favour of hysteria. The cords did not come into line, there being a gap of crescentic shape between them.

Dr. STCLAIR THOMSON, in reply, said one cord seemed to be moving better than the other, which he believed to be against the view that it was functional. But still, he thought it was functional, because when she came to his throat-room she developed a good deal of stridor as she approached his chair. She was in the ward a week, and was carefully watched there at night, when there was no stridor whatever. He had never been able to get her to dilate her cords.

SPECIMENS AND DRAWINGS ILLUSTRATING VARIOUS PATHOLOGICAL CONDITIONS OF THE NOSE AND THROAT.

Shown by Dr. LOGAN TURNER.

(1) *Larynx of a boy from a case of sudden death.*—The specimen shows a large papilloma attached to the left vocal cord. Almost the whole lumen of the larynx above the level of the glottic chink was filled up by the tumour. The boy, aged ten, had always enjoyed good health, and had never required medical advice. His mother stated that she had occasionally noticed a slight hoarseness of voice, but it was never sufficiently marked to call for special advice. He had never been troubled with shortness of breath or any choking sensations, and he had been able to run about and

play with other boys. He died suddenly while eating his dinner without any premonitory symptoms. He appeared to choke. Professor Harvey Littlejohn, who performed the *post-mortem* examination, very kindly handed over the specimen of the larynx to me. When the larynx was removed, the appearance presented by its upper aperture suggested its occlusion by a piece of meat. After washing the parts, and thus removing all the secretion, the upper aperture of the larynx was found to be almost completely occluded by a papillomatous tumour. When the larynx was divided and its interior examined, the papilloma was found to be attached to the left vocal cord.

The case is one of great interest, not only clinically, but also from a medico-legal aspect. It is difficult to realise how the child had remained free from any symptom calling for medical advice.

Keratosis of the larynx.—The patient, A. R.—, aged sixty-four, who followed the occupation of green keeper upon a golf course, was admitted to hospital complaining of hoarseness and some pain in the throat. He had been engaged in this outdoor occupation for ten years, previous to which he had worked as a miner in the coal-pits for thirty-five years. He had been subject to asthma for the last twenty years, two of his sisters being similarly affected. His present occupation exposes him to every kind of weather.

About twelve months before his admission he caught a severe cold; since then he has been constantly hoarse. During the last three months he has complained of occasional pain in the region of the larynx. He is also troubled a good deal with cough and some expectoration.

Examination of the nose, fauces, and pharynx showed no abnormal condition. On laryngoscopic examination, however, a very unusual appearance was observed. The upper surface of the right vocal cord throughout its entire length presented an irregular, mammillary appearance, the free edge of the cord having an irregular outline. Posteriorly this appearance was not confined to the true, but passed without any delimitation on to the upper surface of the false, cord. The anterior two thirds of the left vocal cord showed an exactly similar appearance, but here the condition was limited, the false cord being unaltered and the posterior third of the true cord showing no alteration from the normal. The affected areas were of a greenish white colour. On closer inspection, the impression conveyed was that the affected parts were covered by a firm membrane made up of a number of small pin-point excrescences projecting above the surface of the surrounding

mucous membrane, not unlike a number of small stalagmites, which could not, however, be separately differentiated the one from the other. Dr. McBride, who saw the case with me, expressed the opinion that it was probably one of keratosis of the larynx. This view was confirmed by microscopic examination; under cocaine anaesthesia I removed with forceps a portion of the membrane, which was firm in consistence and fairly adherent to the underlying parts.

An examination of the tissue removed was kindly made for me by Dr. T. Shennan. The pathological condition is well shown in the microscopic sections. The excrescences are made up of numerous layers of cornified epithelial cells. Upon the free surface the most superficial layer is becoming broken up into a number of small detached and semi-detached fragments, portions of which have become shed, forming débris. Some of the deeper cornified layers, again, present a teased-out appearance. Towards the base of the excrescence the stratified appearance becomes lost and a thick layer of epithelial cells is visible. Unfortunately, none of the sub-epithelial tissue had been removed in the forceps, so that its histological appearances are unknown. Here and there upon the surface clumps of branching mycelia are seen, evidently some form of lepto-thrix.

(3) *Pachydermia of the larynx*.—The patient was a married woman aged twenty-five. She was very well nourished and had always enjoyed good health. She had had two children. The family history was good, there being no lung trouble. Four years before first coming under observation she began to be troubled with hoarseness, which had continued more or less constantly since that time. The patient had no expectoration, and examination of the chest revealed no evidence of pulmonary disease.

Nothing abnormal was observed in the nose, naso-pharynx, or pharynx. On laryngoscopic examination the interarytenoid space was seen to be occupied by a greyish-white infiltration, the heaping up being greater in the mesial plane. The surface presented a slightly uneven appearance, but there was an absence of any mesial furrow. The posterior third of the right vocal cord had a ragged, eaten-out appearance, suggestive of a tuberculous ulceration. The left vocal cord was perfectly normal. The long duration of the symptoms and the absence of any evidence of tubercle in the lungs favoured the diagnosis of pachydermia.

(4) *Diffuse papilloma of the larynx*.—A woman, aged forty-four, had suffered from hoarseness for eight years, with gradually

increasing difficulty in breathing. Since childhood she appears to have had frequently attacks of hoarseness, but these were associated with colds, and the voice was not permanently impaired until eight years ago. She had never had the larynx examined until the autumn of 1905. She has occasionally coughed up small pieces of "flesh," but no bleeding occurred at these times. Difficulty in breathing has been increasing lately. Her general health is good. Her father died of phthisis.

When the larynx was first examined the anatomical structures beneath the upper aperture were not recognisable; both false cords, the true cords, and the posterior surface of the epiglottis presented a mass of papillomatous-like tissue, the lumen of the cavity being very much diminished.

The whole of the tumour, with the exception of one or two fragments, has been removed, piece by piece, by endolaryngeal operations. The microscope has revealed nothing but simple papilloma structure.

(5) *Fibroma of the larynx.*—The patient, a male, aged thirty-three, had complained of slight hoarseness for several months. Laryngoscopic examination revealed the presence of a small, pink tumour attached to the free edge of the left vocal cord at the junction of its anterior and middle thirds. The tumour was somewhat pear-shaped, with its long axis lying in the antero-posterior diameter of the glottic chink, the larger end of the growth being anterior. It was attached to the vocal cord by a short pedicle situated about the centre of the tumour. On phonation it became tilted on to the upper surface of the left cord, thus allowing the two cords to approximate, a circumstance which accounted for the small amount of hoarseness of voice which was present.

(6) *A case of lobulated, encapsulated tumour attached to the posterior wall of the naso-pharynx which presented the clinical features of a simple tumour, but which microscopically proved to be a sarcoma.*—A male, aged fifty, a house painter, had always enjoyed good health. He presented himself for examination because a friend of his had recently undergone an operation for malignant disease of the throat. He gave the following history: Two years previously he had suffered from a severe cold accompanied by pain in the throat. While examining his own throat he noticed a swelling of some size, which at the end of about a fortnight burst and discharged a white, tough material which the patient says he was able to remove by means of a fork. Healing took place, but some swelling has persisted since that time. It has given him no trouble

for the last two years, but for the reason stated above he sought medical advice. Examination of the pharynx revealed nothing abnormal, the soft palate presenting a normal appearance and not bulged forwards. By a peculiar movement, evidently acquired by practice, the patient was able to draw his soft palate upwards, so that he could then bring into view when the mouth was opened a tumour which projected downwards and forwards beneath the elevated palate. The mass which thus became visible was of firm consistence, circumscribed, but freely movable upon the posterior wall of the naso-pharynx to which it was attached. It was encapsulated and lobulated, four small lobules making up the main mass of the tumour. There was no ulceration of the surface, but a few small distended veins were visible upon its surface. There was no pain on pressure. There were no enlarged cervical glands. There was evidently no attachment to the periosteum of the vertebræ or basis crani, the mucous membrane of the posterior naso-pharyngeal wall being the seat of attachment.

The tumour was easily dissected out under local anaesthesia, an incision being made round its base of attachment. It had no deep attachments. The base of the tumour measured two inches in circumference. One year after the operation the patient was in excellent health—merely a smooth cicatrix was visible and there were no enlarged cervical glands.

The microscope shows that the tumour is made up of sarcoma-cells of the round-celled variety. The tumour has a dense fibrous capsule.

(7) *Ulceration and destruction of the soft palate and posterior pharyngeal wall.*—The patient was a woman aged thirty-seven, the subject of acquired syphilis.

(8) *A dense fibrous tissue diaphragm completely shutting off the pharynx from the naso-pharynx with the exception of a small, circular aperture placed mesially, which admitted the point of a surgical probe.*—The patient was a young woman aged twenty, the subject of hereditary syphilis. It was found on operation for removal of the diaphragm that both choanæ were completely obstructed by dense fibrous tissue.

(9) *Large cyst of the right ventricular band.*—The patient was a labourer, aged forty-seven, who had first noticed slight hoarseness two years before he came under examination. This at first tended to become worse, but during the last eighteen months the voice has remained much the same, being characterised by a moderate degree of hoarseness. During the last three or four months he

has had difficulty in swallowing water, a choking sensation being produced during the act. Solid food was swallowed with ease. Lately during exertion he has had some difficulty in breathing, but not when at rest or when lying in bed—otherwise he enjoys good health.

Laryngoscopy showed the interior of the larynx almost completely filled up by a large, smooth, spherical swelling occupying the position of the right ventricular band, and concealing from view both true cords and a portion of the left false cord. The swelling extended outwards and involved the right ary-epiglottic fold, passing even beyond that, while anteriorly it passed on to the posterior aspect of the epiglottis. It presented a tense appearance, the vessels upon its surface being dilated, and giving the impression that there was fluid within the swelling.

Under cocaine the tumour was incised with Heryng's knife ; it immediately collapsed, a quantity of clear, gelatinous-like material being extruded and spat up. Some thickening of the right ventricular band remained for a considerable time, but at the end of a year all trace of the cyst had disappeared.

Dr. PEGLER said, in reference to the case of keratosis of the larynx, it had just been stated that there were only four recorded cases of that condition. He believed, however, that the case of the patient with white accumulated excrescences on the vocal cords, shown by Dr. Scanes Spicer at the last meeting, was one of keratosis of the cords due to lepto-thrix buccalis or mycosis. It corresponded, as suggested by Sir Felix Semon at the time, closely in appearance to this drawing of Dr. Logan Turner's case. He (Dr. Turner) had kindly consented to send a microscopical specimen to the Society so that the sections of the two cases could be compared.

WOMAN AGED FIFTY WITH MALIGNANT GROWTH IN NASO-PHARYNX; QUESTION OF OPERATION.

Shown by Mr. DE SANTI. This patient has a large cauliflower-like growth in the naso-pharynx, growing downwards so as to be visible in part below the level of the palate. It is hard to the touch and extensive in its attachments. There are deep-seated glands in the neck. She has had sore throat since the summer, but until lately has not consulted any medical man. She is brought before the Society for an expression of opinion about operation. Mr. de Santi considered the condition to be too extensive for operation.

Mr. CRESSWELL BABER asked whether the patient had been given iodide of potassium.

The **PRESIDENT** thought it seemed too deep for operation. There was tenderness over the glands, but he could not say whether they were infected.

Dr. LOGAN TURNER recommended putting the patient upon iodide of potassium if that had not been done. There was an absence of the characteristic cervical glandular enlargement such as one would have expected with malignant disease.

Mr. DE SANTI, in reply, said the patient had not been given iodide of potassium; he only saw the patient a few days ago. He would do so, although he considered that no benefit would accrue. There were deep-seated glands to be felt in the neck.

CARCINOMA OF THE NASO-PHARYNX.

Shown by **Mr. CHARTERS SYMONDS**. Mr. T—, aged fifty-five, was brought to me for a gland in the right side of the neck and for some deafness and obstruction of the right nostril. There was found projecting a rounded swelling, quite easily seen, concealing the right Eustachian tube and obstructing the nostril on the right side. The lump was smooth in outline, firmly attached to the pharynx; the surface appeared to be unbroken, but it had bled a little on handling. There was one principal gland beneath the sterno-mastoid on the right side and one or two smaller ones.

As the growth seemed to be irremovable he was put upon arsenic, and at the end of a fortnight there was a distinct improvement in the size of the cervical glands, and when last seen (March 27, 1906) the glands seemed to be still smaller, but the growth remained in about the same condition. The view I took of the case was that, from the situation of the disease, from its character, and from the enlarged glands, it was not worth while to submit the patient to an operation as it would be impossible to completely extirpate the disease. It may be added, moreover, that he has been operated upon successfully for cataract, and though fairly vigorous in other respects, this indication of senile change must also be taken as operating against interference. When shown at the meeting the growth projected towards the soft palate, having increased considerably.

The **PRESIDENT** said he regarded the case as inoperable, but possibly others might take a different view.

Dr. DUNDAS GRANT said the question arose whether the immobility of the right half of the palate was due to the mechanical pressure of the growth, or to involvement of the vagus nerve by the growth. Perhaps the President could say, if he had palpated it.

The **PRESIDENT**, in reply, said he thought the effect produced was mechanical; the palate was not infiltrated, but was very much pressed forward.

A WOMAN WITH LARGE SESSILE TUMOUR IN LEFT ARYTENOID REGION.

Shown by Mr. CARSON.

Dr. WILLIAM HILL said the cord moved very fairly on that side, and it occurred to him that it was not the arytenoid at all which was very much involved, but that the growth came from the upper and back part of the cricoid. If digital examination were made under an anæsthetic, it might be localised a little more certainly. It might be sarcoma.

Dr. SCANES SPICER said the condition might be ulceration of an encapsulated fibroma.

The PRESIDENT said he feared it was epithelioma of the pharynx, coming up from below and involving the arytenoid region in that direction. One could see a broad ulcerating surface, and it was very solid. To the finger it was not so hard as ordinary epithelioma. Epithelioma in a woman was particularly apt to involve that region. The present patient was older than most he had seen, and he thought but little could be done for the condition.

Mr. DE SANTI regarded it as a case of pharyngeal epithelioma similar to those described by Professor Gluck. The only thing which it was possible to do for the patient was to remove the whole pharynx and larynx, as Professor Gluck did. The patient, however, might not survive it.

Mr. CARSON, in reply, said there would be no difficulty in removing a piece of the growth for microscopical examination. That he proposed to do, and would report the result later.

A MAN WITH AN ULCERATED SWELLING IN THE MIDDLE LINE OF THE NASO-PHARYNX AND ULCERATION OF THE LEFT POSTERIOR FOLD OF THE PALATE.

Shown by Mr. CARSON.

Dr. DUNDAS GRANT thought the diagnosis lay between gumma and epithelioma. The intense hardness of the parts surrounding the ulcer suggested epithelioma, but the absence of pain was then rather difficult to explain. He did not think that feature excluded the diagnosis of epithelioma.

CASE OF FIXATION OF THE RIGHT ARYTENOID IN A WOMAN AGED FORTY; FOR DIAGNOSIS.

Shown, in the absence of Dr. FURNISS POTTER, by Dr. DAVIS.

The PRESIDENT said he noticed that there was some movement of the vocal cord, while the arytenoid seemed fixed.

Dr. H. J. DAVIS said Dr. Potter, who was absent, was very anxious to have an opinion on the case. The symptoms had been in existence only eight months, and Dr. Potter thought it very peculiar that though

the arytenoid was fixed on that side the cord on that side moved. He (Dr. Davis) thought it looked like a mechanical partial fixation of the arytenoid.

A WOMAN AGED TWENTY-FOUR, WITH A SWELLING ON THE UPPER PART OF THE SEPTUM NASI; FOR DIAGNOSIS.

Shown by Dr. DONELAN.

Dr. DONELAN said the swelling had disappeared, and there was haemorrhage, but that did not account for the foetor. Yesterday there was a most unpleasant odour.

Mr. CRESSWELL BABER remarked on the deflection of the septum to the right side. The swelling which had existed on the left side was probably an influenza abscess of the septum.

CHILD AGED TWELVE WITH GROWTH ON THE LEFT SIDE OF THE TONGUE.

Shown by Mr. DE SANTI. This patient was sent to Mr. de Santi from the country for operation for adenoids and tonsils. On examination of the mouth it was found that the left side of the tongue was occupied by a papillary hypertrophy extending nearly all its length. The only inconvenience to the patient was the getting of the papillary mass in between the teeth. The condition of the tongue had not been noticed by the parents.

Mr. de Santi had never before seen so extensive a papillary hypertrophy of the tongue, and proposed to remove it with a knife.

Dr. H. J. DAVIS said that he considered the condition one of lymphangiectasis, though he was really indebted to others for the opinion.

The PRESIDENT thought it was a simple hypertrophy of the side of the tongue, because it did not collapse on pressure. He did not think it was more than a redundant fold, a congenital condition. The point which would decide as to removal would be the inconvenience caused. If it got bitten and bled it should be snipped off.

Mr. DE SANTI, in reply, said the condition got in the way of her teeth, but did not otherwise inconvenience her.

CASE OF INFILTRATION, WITH FIXATION, OF THE RIGHT VOCAL CORD IN A MAN AGED FORTY-SIX.

Shown by Dr. DUNDAS GRANT. The patient is a man aged forty-six, a printer, formerly in the habit of using his voice a great deal for public speaking and preaching. He was first seen on March 2, 1905, on account of hoarseness, almost amounting to loss of voice. There was then found a swelling of the anterior part of the right vocal cord and a small growth presenting the appearance

of a fibroma ; this was partially removed by means of forceps and several applications of the galvano-cautery. He was then lost sight of, and in October, 1905, appeared with a red general swelling of the right vocal cord, underneath which could be seen a small, apparently superficial, ulcer of oval shape. This unilateral infiltration of the vocal cord, with the shallow ulcer on its inner border, was looked upon as probably tuberculous, especially in view of the fact that two of his children were suffering from tuberculosis ; there was, however, no disease detectable in the chest, and the examination of the sputum revealed no tubercle bacilli. He was not again seen till yesterday, and then it was found that the infiltration extended into the ventricular band and that the mobility of the vocal cord was markedly diminished.

The exhibitor would be glad of opinions regarding the appearances which, although not characteristic of malignant disease, are certainly suspicious.

The PRESIDENT thought the case was in many ways the most important that had been brought forward at that meeting. It was difficult for him to be quite sure about it, but he thought the left vocal cord was a little œdematosus. He asked how Dr. Grant would interpret the condition of the left vocal cord in its relation to the right, whether it was an accidental laryngitis or not.

Dr. STCLAIR THOMSON said that if there had been no traumatism he would regard it as malignant fixation of the cord ; there was a purplish look about the whole cord.

Mr. ATWOOD THORNE said he understood that some of it had been removed by Dr. Grant. He would like to know if there had been any microscopical report on the portion removed.

Dr. GRANT, in reply, said the case was first seen a year ago, when it seemed to be simple granulation tissue. He did not think there was sufficient removed to enable a microscopical examination to be made.

PROCEEDINGS
OF THE
LARYNGOLOGICAL SOCIETY OF LONDON.

ONE HUNDRED AND SIXTH ORDINARY MEETING, *May 4, 1906.*

CHARLES J. SYMONDS, F.R.C.S., President, in the Chair.

HENRY J. DAVIS, M.B.
W. JOBSON HORNE, M.D. } Secretaries.

Present—39 members and 2 visitors.

The minutes of the previous meeting were read and confirmed.

The following gentlemen were nominated for election at the next meeting as ordinary members—

JOHN DAVIS LITHGOW, M.B., C.M., F.R.C.S.Edin.
DUNCAN MATHESON MACKAY, M.D., C.M.Edin.

The following communications were made :

THREE CASES OF SYPHILIS IN ONE FAMILY, (?) COMMUNICATED BY
ORAL INFECTION FROM ONE TO THE OTHER; WITH PHOTOGRAPH.

Shown by Dr. H. J. Davis. The three patients were exhibited. The first to develop syphilis was a child aged eleven. There was no evidence of genital infection, and she was a virgin, and first attended under his colleague Dr. Abraham, in the skin department of the West London Hospital last autumn, with a "dusky, macular eruption on arm, legs, body ;—tonsillitis, severe adenitis, and enlarged glands in neck and groin, but no appearance of primary sore." She was treated with mercury, and the rash soon vanished under treatment.

The child's grandmother, aged sixty—a widow fourteen years—nursed and slept with the child during her illness. Last December she became ill, and in February came under his (Dr. Davis') care, looking extremely ill with tonsillitis, adenitis, a typical rash,

and early iritis, and she was at the present moment suffering from virulent syphilis. There was no evidence of any primary sore.

A fortnight ago the child's aunt, who was inhabiting the same flat as the child and her grandmother, attended in the surgical out-patient department of his colleague Mr. Baldwin, with a chancre inside the right nostril; indurative œdema and adenitis were very marked, and the appearance was suggestive of malignant disease of the nose and upper jaw.

At the present time there were mucous patches on the tonsils, early roseola, and the primary sore could be seen at the junction of the skin and mucous membrane of the right nostril. There was still considerable infiltration and œdema, but the local conditions had subsided rapidly under mercury.

Dr. Davis thought the sequence of cases of great interest, and he had no doubt that the woman contracted the disease from her grand-daughter, and communicated it to her daughter by oral infection. Photographs of the three patients were exhibited.

The PRESIDENT asked if there was any history showing how the child became infected.

Dr. J. DONELAN also asked how the family became infected. He had occasion to look up the literature of extra-genital chancre lately, as during the past few years he had seen some cases in which the disease could not have been contracted in any vicious way, or by kissing, the only possible channel of infection being the use of spoons, etc., in a family where the foreign butler was suffering from buccal syphilis. Those who had to do with the foreign population of London must be struck with the number of cases of chancre of the tongue, and wonder that these extra-genital chancres were not more frequent now that restaurants were so much more frequented than formerly. The subject of extra-genital chancre was of much interest, and Sendziak had published a number of cases including chancres of the nose and ear. One of the most curious instances was that of a primary chancre of the pleura, reported by Dominicis. He desired to compliment their visitor Mr. Aslett Baldwin on his excellent photographs, which showed the great value of orthochromatic plates in recording morbid conditions.

Mr. ASLETT BALDWIN thought his case of chancre in the nose was of interest because of its rarity, and also because of its similarity to malignant disease; in fact, several who saw it at first suggested that diagnosis. When the woman was first seen, eight days ago, she looked and felt extremely ill, and had severe pain in the nose. She had been taking mercury for the above time, and was already much better. He thought the series of cases showed the importance of warning patients with syphilis that the disease is communicable.

Dr. DAVIS, in reply, said in July of last year the child went to a bean-feast, and the first symptom of syphilis that she had was severe tonsillitis. She was still taking iodides. Her grandmother, who slept with her, contracted the disease about Christmas, and had severe tonsillitis, but no

sign of a primary sore. A few months later a daughter attended Mr. Baldwin's out-patient department with a sore in the nose. Dr. Abraham, under whose care the child had been, had told him that it was not uncommon in South Africa for syphilis to run through a family without any evidence of a primary sore: they had simply tonsillitis and a rash. He had never met this in England.

FISH-HOOK REMOVED FROM THE OESOPHAGUS.

Shown by Dr. D. R. PATERSON. A boy, aged thirteen, swallowed a fish-hook about the size of No. 7 Limerick, and was admitted to hospital with the loop of the gut protruding beyond the teeth; on pulling on the gut pain was felt in the centre of the chest. A skiagram showed the hook impacted opposite the fifth dorsal vertebra. Chloroform was administered and an oesophageal tube passed over the gut into the gullet, where the hook was seen fixed in the wall to the left side. The long tubular end-piece of a saliva pump was now threaded over the gut and passed down so that its bulbous end rested on the point and barb of the hook. When the gut was pulled tight complete power was obtained over the hook, which was easily detached and removed.

TOOTH-PLATE REMOVED FROM THE OESOPHAGUS.

Shown by Dr. D. R. PATERSON. The patient, a woman aged thirty-six, swallowed, during sleep, a tooth-plate having four teeth and two hooks or clasps. A skiagram showed it opposite the supra-sternal notch. Fortunately no attempt had been made to dislodge it by probang. An oesophageal tube was pressed down and the plate was removed by the straight laryngeal forceps.

SKIAGRAM OF THE NECK IN A CASE WHERE A PIECE OF MEAT WAS IMPACTED IN A STRICTURE OF THE GULLET.

Shown by Dr. D. R. PATERSON. This case was a lad who had "a small swallow" for some time. In the attempt to swallow a piece of meat it stuck in the gullet and blocked it so that nothing could be passed. Attempts were made by probang and coin-catcher to push the obstruction down, and considerable force was used without result. Twenty-four hours afterwards on admission to hospital the lad looked very ill, had a high temperature and a rapid pulse, and much swelling on the left side of the neck, with distinct emphysematous crackling. He was quite unable to swallow

anything. Under chloroform great swelling and œdema of the entrance of the œsophagus and about the left pyriform sinus were seen. An œsophageal tube was passed, and opposite the cricoid cartilage an impacted piece of beef was removed. There was narrowing of the gullet at that point. Swallowing was at once re-established. Gradual recovery took place. Considerable damage had been inflicted by the probang and coin-catcher, and this case indicated that their indiscriminate use should be discouraged, more especially as we have now instruments of precision.

LEFT RECURRENT PARALYSIS AND PARALYSIS OF THE SOFT PALATE
ASSOCIATED WITH MIDDLE-EAR DISEASE AND FACIAL PALSY ON
THE SAME SIDE.

Shown by Dr. D. R. PATERSON. A female, aged twenty-four, noticed deafness in the left ear which was followed by facial palsy three or four weeks later. Six months later still weakness of voice was observed, with occasional uncertainty in swallowing. This has remained practically unaltered. At the present time the left recurrent nerve is paralysed and the soft palate is weak on that side. There is complete left facial palsy. She hears nothing in the left ear; the bone-conduction is increased and the inner part of the meatus is swollen and has a vivid red appearance. No details of the membrane can be made out, the swelling being somewhat resistant to the probe. There is no headache, and the eyes are normal. She has been under observation for two months and there has been no apparent change.

Dr. DUNDAS GRANT, referring to the case of recurrent paralysis, said the later history would be very important. There was a combination of nerve-lesions which pointed to something near the apex of the petrous bone, such as might be due to tubercular disease or to new growth. But with regard to the latter there was a singular absence of glandular enlargement in the neighbourhood. He asked whether there was anything in the naso-pharynx or in the history to account for it.

Mr. BARWELL asked whether the ear-drum was normal and whether the deafness was of the nerve or the middle-ear type. He did not understand whether there was suppuration in the middle ear when the attack of facial paralysis came on or whether it was nerve-deafness arising at the same time as the lesion of the other nerves.

Dr. STCLAIR THOMSON said he had a case, of which his memory was somewhat hazy, about eight years ago, the record of which was in the *Clinical Society's Transactions*. It was somewhat similar to the present case. The patient was a man aged thirty-six, and was brought because of difficulty in swallowing; there was paralysis of the recurrent laryngeal nerve on the left side. The history given was that one year and a half

previously the patient was under Dr. Urban Pritchard for Ménière's disease. He had a thickened, red, bulging drum, and nerve-deafness on that side. The case at first was taken to be early malignant growth of the œsophagus; the condition of the ear was thought to be merely a coincidence; and the symptoms in the ear and the throat were not regarded as associated. He died of an intra-cranial growth. There were no enlarged glands and the progress of the case was remarkably slow.

Dr. DONELAN thought the case was of centric origin, perhaps due to a tumour affecting the pons or embolism in that region, as it appeared to be an irregular form of Avellis' well-known group of symptoms. Where the palate and vocal cord alone were associated the lesion was generally peripheral. A number of cases had been recorded where paralysis of the shoulder was associated with that of the palate and vocal cord. He had not seen any case in which the facial was included, but he believed some rare cases reported by members of this Society are referred to in Professor Poli's excellent paper in the current number of the *Italian Archives of Laryngology*. He thought the engorgement of the tympanum was due to implication of the sympathetic.

Mr. CLAYTON FOX asked if there had been any giddiness. It appeared to suggest sarcoma of the dura mater, starting from the posterior part of the petrous bone, involving the seventh, eighth, and ninth, and vago-accessory nerves. The patient had distinct difficulty in swallowing.

Dr. WILLIAM HILL said he did not think it was made clear whether the auditory nerve was involved. Possibly the middle-ear disease had nothing to do with the nerve-lesion which had produced the facial paralysis and the affection of the recurrent laryngeal.

Dr. PATERSON, in reply, said there had been nothing in the naso-pharynx, nor any suppuration in the ear. She heard nothing on that side, and bone-conduction was increased there. It appeared as if the middle ear were pushed out; the swelling on the floor of the meatus was distinctly hard to the probe. Therefore he did not think vaso-motor changes would account for it. There was no giddiness, and the onset of the deafness and the facial palsy were practically simultaneous. She had been having 30 gr. a day of iodide of potassium during the past two months, but without any change, and, according to the patient's account, there had been practically no alteration in two years.

The PRESIDENT said it was possible there was a growth, and members would be glad to hear the after-history of the case.

BILATERAL ULCERATION OF THE POSTERIOR SEGMENTS OF THE VOCAL CORDS IN A MAN.

Shown by Dr. H. PEGLER. There had been temporary improvement under iodide of potassium.

Dr. DUNDAS GRANT thought it was a beautiful case of pachydermia. The patient had been a vegetable dealer, and a hawker previously to that, occupations leading to excessive strain on the vocal cords.

The PRESIDENT also thought it was a case of pachydermia because of the mobility of the cords and the depressed points, with soft tissue round them and the way in which they became flattened. The patient was young for it, but perhaps that did not matter if the habits were sufficient.

Dr. H. PEGLER expressed his thanks for Dr. Grant's opinion, which accorded to a certain extent with his own view, though the depth of the ulcerations had prevented his regarding it as a typical form of pachydermia. The appearances had altered somewhat from time to time.

A NEW NASAL SAW.

Shown by Dr. E. A. PETERS.

The PRESIDENT asked what was the object of the concavity of the saw.
Mr. H. TILLEY asked what class of case Dr. Peters used the nasal saw for.

Dr. PETERS, in reply, said the saw was very rigid, and the concavity fitted in with the direction of the cut. He admitted that submucous dissection had made a good deal of difference in operating, but there were some cases, particularly where there was a spur from the floor of the nose, in which removal was difficult by the submucous method. He thought there was still room for a saw.

FOUR CASES OF CHRONIC FRONTAL EMPYEMATA OPERATED ON BY A SIMPLIFIED KILLIAN OPERATION.

Shown by Dr. HERBERT TILLEY. CASE 1.—Child aged six and a half, who had already been operated upon for chronic suppuration of the lacrymal sac (left). The fronto-ethmoidal cells were in an empyematous condition.

CASE 2.—Young adult, aged twenty-five, dermoid cyst over right eye, beneath external angular process. Nasal suppuration present, and found to be due to chronic empyema of right maxillary antrum. Frontal sinus healthy.

CASE 3.—Female, aged twenty-three. Bilateral fronto-ethmoidal empyemata. The left side treated by older method, viz. free opening of sinus, followed by "packing," the right by a simplified Killian operation, with immediate closure of the wound.

CASE 4.—Male, aged fifty-three. Chronic empyemata of left fronto-ethmoidal sinuses. Simplified Killian operation. Immediate closure of wound. Discharged from hospital eight days after operation. Almost total absence of visible scar.

The "simplification" referred to consists in leaving the floor of the frontal sinus untouched, otherwise the procedure is the same as in Killian's operation.

Dr. DUNDAS GRANT said he did not think Killian always removed the floor of the frontal sinus. He (Dr. Grant) agreed with Dr. Tilley, that removing the floor added considerably to the laceration, and if such results were obtainable in all cases without removing the floor, it was

very desirable. In a recent case he used exactly the method shown by Dr. Tilley, and when it came to be a question of removing the floor, he felt he would rather leave it alone, as it added to the difficulty of an operation already not simple. The case eventually did very well. The friends were delighted with the absence of deformity. The great point which Killian had brought out was the ingenious method of preserving the bridge along the upper margin of the orbit, and the elderly man in Dr. Tilley's series showed how perfect the result might be in regard to disfigurement. The scar in the little girl was more prominent, though in time that might disappear. Perhaps the healing was complicated by the suppuration in the lacrymal sac. Whether the floor was removed or not, one should practise the preservation of the bridge over the margin of the orbit and the opening through the ascending process of the superior maxilla. Those who had not done this could have no idea of the magnificent access it gave to the ethmoidal cells.

Dr. SCANES SPICER said that in many such cases the procedure was attended by much scarring of the face. He thought that equally good results could be obtained by the less extensive operations which were generally adopted eight or ten years ago. The scars on the faces of the woman and girl shown to-day were both serious. Of course, if one had operated two or three times by removing the middle turbinate body, destroying the ethmoidal cells, and doing the old operation followed by trephining the anterior wall and curetting, then if necessary, one might justifiably go on to extirpation of the lower part of the cavity. One should be very guarded about saying a frontal sinus case was *cured* if there was no pus seen. He had been deceived in many cases in that matter. Even nine months after an apparent cure a cold seemed to light up the whole thing again. He was not clear why the term "dermoid cyst" was applied to one case. He understood the frontal sinus was not suppurating, but he had seen one or two similar cases which had led into the frontal sinus, owing to the extension of that sinus outwards.

Mr. STUART-LAW said there was no scar in Killian's cases, whose results were marvellous, and this was largely due to his skill in bringing the edges accurately into apposition by means of aluminium wire sutures. He made slight transverse incisions at intervals simply through the cuticle, so that he might more readily and directly appose the edges in stitching up. It was altogether incorrect to say that because Killian removed the floor of the frontal sinus diplopia frequently followed. Diplopia seldom happened even when the trochlea was removed, which occasionally occurred. He confessed to a feeling of disappointment since examining these cases as the scarring amounted to permanent disfigurement, and it was questionable whether a radical remedy had been effected.

Mr. HERBERT TILLEY, in reply, said whether as good results could be obtained with a smaller operation depended on the nature of the case. If there was extensive infection of ethmoidal cells a larger operation must be performed than when the frontal sinus was alone diseased. Dr. Spicer had said that in some of the patients shown there was still a complaint of a purulent discharge. In the case of the boy who had the dermoid cyst the radical maxillary operation was performed on the right side only ten days ago, and the secretion he complained of was merely the mucus from the granulating cavity, and as the frontal sinus was not affected in this case it was scarcely fair to speak of it as "still discharging." In reply, again, to Dr. Spicer, a dermoid cyst was spoken of because there

was a large tumour pressing the eyeball downwards and outwards, and when it was opened cheesy material came away, which the microscope showed to consist of the contents of a dermoid tumour. This patient showed a considerable deformity, but that was entirely due to the dermoid cyst and had nothing whatever to do with the sinuses. He was not ungrateful to Mr. Low for his criticisms, and he (the speaker) felt that the operative procedure upon the sinuses had not been reduced to perfection. His recent cases, he thought, would show as good results as could be wished. If more care were taken in suturing the external wound he thought as good cosmetic results would be obtained here in London as elsewhere. He would be quite content if he could always obtain as good a result as was exemplified in the case of the man shown to-day. The little girl's case was, again, scarcely a fair one to criticise from the point of view of the operation on the frontal sinus, because not only was it recent and had not had time to heal, but when the patient was transferred to him there was a suppurating fistula over the lacrymal sac and the surrounding skin in a state of inflammation, so that he was operating on a case which was unfavourable to start with. If he had been intent on showing his best results from the cosmetic point of view, he would have brought forward only the man on whom he operated last week, and who had had no previous operations performed.

A CASE OF TUBERCULOSIS OF THE SOFT PALATE, THE PHARYNX, AND THE EPIGLOTTIS.

Shown by Mr. CLAYTON FOX. On April 11, 1906, a woman of delicate appearance, aged thirty-two, was admitted as an in-patient at the Metropolitan Nose, Ear, and Throat Hospital, complaining of sore throat, pain on swallowing, cough, and accumulation of phlegm, of seven months' duration (she had previously been treated as an out-patient).

Family history.—One brother had had three attacks of pleurisy; all other members of family healthy. No history of phthisis, syphilis, gout, or rheumatism.

Previous history.—Her health had been good till last August, when the throat began to trouble her. Two children born alive, both very weakly. One miscarriage, four years ago.

On admission.—There were several greyish-white hemispherical nodules on the pillars of the fauces and velum, especially above and on either side of the base of the uvula; some had broken down, leaving roundish, shallow ulcers with grey bases, and devoid of any reactionary areola.

Where the posterior pillars of the fauces shade off into the pharyngeal wall there was on either side an elongated, shallow ulcer with greyish-yellow speckled base and irregularly-shaped

nibbled edge, the latter slightly raised above the neighbouring mucosa. The left anterior pillar had a clean, red, nibbled appearance, no slough being present. There was marked pallor of the mucosa of the hard palate, velum, and fauces. There were two small ulcers elongated in shape and having an eaten-out look on the laryngeal aspect of the free border of the epiglottis. Both arytenoids and the right ventricle bands were swollen. Some of the upper deep cervical glands of the left side were slightly enlarged. An examination of the lungs revealed some impairment of resonance over the upper right lobe. Inspiration was wavy, with prolonged expiration over this area, whispering pectoriloquy was present. Sibilant rhonchi on expiration were present on some days over the whole of the right lung. There were no other adventitious sounds. Patient has had a temperature of remittent type since February 28, accompanied by night-sweats and loss of flesh. Sputum has been examined on two occasions, with a negative result. On April 18 attention was called to an ulcer on the posterior part of the left labium majus, elongated and oval in shape, the base covered with pale granulations and edge indolent and livid. Neither the base of this ulcer nor the tissues around were indurated. The inguinal glands on the same side were slightly enlarged. The post-nuchal, the suboccipital, the epitrochlear, and the glands generally were not enlarged. There was no rash present. Patient has been treated with iodide of potassium and quinine, also with iodide of potassium and mercury. Locally a mixture of carbolic acid, formalin, and lactic acid has been rubbed into all the ulcerated parts, and vapour creosoti has been inhaled.

The chief points of interest in this case are :

- (1) As to whether the pharyngeal and laryngeal lesions are the result of one syphilitic inoculation.
- (2) Are the lesions pharyngeal and vulvar tubercular ?
- (3) Is the vulvar sore a chancre, the secondary symptoms not having yet appeared ?
 - (1) It would be difficult to reconcile the fact that a sore of two months' duration could be associated with such pronounced pharyngeal and laryngeal ulceration without other manifestations of secondary syphilis, rashes, mucous tubercle, systemic glandular enlargement, etc., conditions absent in this case.
 - (2) Appearances of the lesions and symptoms favour the idea that all the lesions may be tubercular.
 - (3) Against the vulvar sore being a chancre we are confronted with the facts that it is not indurated, and that although of two

months' standing, the usual secondary phenomena are conspicuous by their absence.

Mr. BARWELL regarded it as tubercle alone.

Mr. CLAYTON FOX, in reply, said he thought it was tuberculosis of the pharynx and epiglottis. His only doubt concerned the lesion on the vulva, which was of two months' duration, and which, except for the absence of induration of the sore and the enlarged inguinal glands, presented the characters of chancre. Against that was its two months' existence, and the absence of secondary phenomena. None of the systemic glands were affected.

A CASE OF SWELLING BELOW THE ANTERIOR COMMISSURE OF THE VOCAL CORDS, CAUSING SOME DYSPNÆA, WITH DEFORMITY OF THE EPIGLOTTIS AND INDURATED SWELLING OF BOTH AURICLES IN A WOMAN AGED FIFTY-FIVE.

Shown by Mr. CHARLES PARKER. The patient had lived in India for two years and in Italy for one year. Eight years ago, after her return from India, she was out on a very cold night, and the left ear suddenly became extremely painful. The pain passed off within twenty-four hours, but the ear gradually enlarged and became very hard. Five years ago, whilst in the mountains of Italy and exposed to great cold, the right ear became similarly affected. For the last two months the patient has suffered from severe cough and the sensation of something in the region of the larynx which she could not expectorate, and for the last six days she has had distinct dyspnœa. At the present time both auricles are enlarged and deformed and of almost bony hardness, and the skin is white and shiny. The auditory meatuses are somewhat contracted, but there is no disease of the tympanic cavities, and the hearing is good. The nose is altered in shape, being more or less of the saddle-back shape; the nasal cavities are normal, except for some thickening of the cartilaginous septum. The naso-pharynx and ovo-pharynx are normal. The epiglottis is of a peculiar shape, thickened and distinctly yellow in colour, suggesting cartilaginous thickening. Abduction of the vocal cords is limited. Below the anterior commissure of the cords a red swelling can be seen extending to the trachea and more towards the left than the right side. In the neck some thickening and great hardness can be felt on the left side over the first few rings of the trachea. There is audible dyspnœa on the slightest exertion and noisy breathing during sleep. The case is shown for the purposes of diagnosis and to elicit opinions as to whether the condition of the ears and the laryngeal changes are due to one cause.

Mr. BUTLIN said he could not be sure about the laryngeal and infra-laryngeal trouble, but thought there was some thickening to be felt from the outside. He had not seen anything like the ear condition in his life. The only condition which it seemed at all to resemble was that which sometimes occurred in the penis of gouty people—a carapace of firm, fibrous material. He had removed more than one of these, and the microscope showed fibrous tissue, perhaps due to degeneration. He did not regard it as a new growth.

Dr. DAVIS said he thought it resembled leprosy. There was infiltration, facial deformity, and silkiness of the skin of the hands, which were characteristics of the disease.

VILLOUS PAPILLOMATOUS GROWTH, PROBABLY EPITHELIOMA (BUT WITH DOUBTFUL HISTOLOGICAL CHARACTERS; A HISTORY OF OLD SPECIFIC INFECTION; ANTI-SPECIFIC REMEDIES NOT YET TRIED), IN A MAN AGED FORTY-SIX.

Shown by Dr. DUNDAS GRANT. The patient complained of pain in swallowing, dryness of throat, which had gradually developed and had lasted two years, while during the last three months there had been some bleeding from the throat. On laryngoscopical examination the cavity of the larynx was almost completely hidden by a red papillated mass of globular form, which at first sight appeared to be growing from the laryngeal surface of the epiglottis. During inspiration and phonation the right half of the larynx seemed to move, and after the extraction of a portion of the growth it was seen that the right vocal cord was normal, both in colour and mobility. The growth when moved by means of a probe appeared to be attached to the left half of the vestibule of the larynx, and several portions of it were removed by means of the snare. It was then seen that the left vocal cord was almost completely fixed, but free from ulceration of any kind. The voice was practically normal, and there was little or no interference with respiration. Microscopical examination of a small portion, removed by means of forceps, revealed thickened epithelium with oedematous infiltration, but no definite signs of malignant and neoplastic process; a large portion removed more recently possessed characters more suggestive of malignant disease, which will be described by Dr. Wyatt Wingrave. There was some enlargement of glands at the angle of the left jaw. The laryngoscopic appearances are highly suggestive of epithelioma, and this is supported by the history of the disease, but the microscopical appearances are so little confirmatory, that the exhibitor thinks it advisable to try the effect of anti-specific remedies in view of the former infection, on

the chance of the growth being one of the proliferated forms of syphiloma. He hopes to show the case again at the next meeting.

PREPARATIONS ILLUSTRATING DR. DUNDAS GRANT'S CASE OF LARYNGEAL GROWTH.

Shown by Dr. WYATT WINGRAVE. Fragments weighing 98 grains were removed at two sittings. They were soft and friable in consistence, mammillated and translucent in appearance.

Microscopically they consist of closely packed spheroidal cells, apparently derived from the surface epithelium of the cords from which they can be traced. The cells are grouped in large masses, separated by a very scanty stroma. Their nuclei are strikingly variable in size, many being four times as large as those of normal squamous epithelium. Mitoses are few and of a somatic type. Extra-cellular chromatin granules are few, lymphocytic infiltration is absent, and there are no concentric "pearls" or "nests."

It is evidently an epithelial growth, papillomatous in type, possessing, however, some striking variations from an ordinary papilloma, yet wanting the definite characters which constitute unequivocal histological malignancy.

Dr. WYATT WINGRAVE thought it was the kind of case in which the histologist could justifiably ask the surgeon to share the responsibility of the diagnosis. There were unmistakable signs of papilloma and an absence of the features of typical epithelioma. The cells possessed remarkably large nuclei, and there was no evidence of mitosis other than was found in somatic cells. The surface was distinctly mammillated, and before going into alcohol presented translucent characters more suggestive of papillary growth than epithelioma. One was justified in being suspicious of the case, because the enlarged nuclei were suggestive of a transition stage from innocence to malignancy.

Mr. BUTLIN said he had examined the case and had come to the conclusion that the condition was one of marked malignant disease. It was partially hidden by a large swelling above, and he thought that possibly Dr. Wingrave had not had a sufficiently characteristic piece to examine. The glands on both sides of the neck were very characteristic of malignant disease. It was, he thought, a hopeless case.

Mr. ROBINSON said he had come to the same conclusion as Mr. Butlin. He thought it undesirable to attempt its removal.

Dr. DUNDAS GRANT, in reply, said the only thing which threw doubt on the diagnosis was the microscopical appearance. The specimen for examination was obtained from deep in the growth, but possibly the characteristic changes would be found deeper. On the chance of its being specific, he proposed giving a course of iodide of potassium and mercury, the effect of which would soon show itself.

CASE OF EPITHELIOMA OF THE PALATE IN A MALE PATIENT AGED SIXTY.

Shown by Dr. DUNDAS GRANT. There is a shallow, oval ulcer of about the size of a shilling, chiefly on the left half of the soft palate but encroaching on the hard. The base of it is not materially indurated, but the edges are distinctly hardened and show a slight tendency to eversion. The patient complains of pain in his mouth, especially when eating or drinking, which has come on gradually and has lasted, as far as he can judge, for about three weeks. The bacteriological examination reveals a few curved spirals of about four turns, fusiform bacillus, and some non-pathogenic organisms; but the bacteriologist, Dr. Wingrave, is unable to say that the *Spirochæte pallida* is present; such epithelial cells as were found in the scraping were normal. There is a hard mass of glands beneath the mastoid insertion of the left sternomastoid muscle. When first seen, three weeks ago, he was ordered 10 gr. of iodide of potassium with a drachm solution of perchloride of mercury, and on the 28th the dose of the iodide was increased to 25 gr.; the induration of the edges of the ulcer has increased in the interval, and the diagnosis of epithelioma is probably correct. Extirpation of the growth and of the glands is proposed.

Mr. ROBINSON thought it an interesting example of the superficial form of epithelioma. Some of those who saw it were suspicious that it might be specific, but he felt no doubt that it was epithelioma. He had several times removed such a condition.

Dr. STCLAIR THOMSON said he did not know whether Dr. Grant thought of operating upon the case with such extensive glands in the neck. He (Dr. Thomson) thought it was much too extensive. It was very much like a case he had in which, bearing out what Mr. Butlin said, pieces were removed for examination and reported to be papilloma, but in which one did not get down to the real growth. His case was shown at the Clinical Society, when all agreed that it was quite inoperable.

The PRESIDENT said the disease did not seem to have broken through the capsule of the glands, and in such cases the glands were renovable. Such palate cases were very favourable for operation, and if it were surgically possible to operate on the case he thought it ought to be done. He judged that it was suitable for operation, the glandular operation being done first, and if the patient bore that well, finishing up with the palate, which could be done in a few minutes.

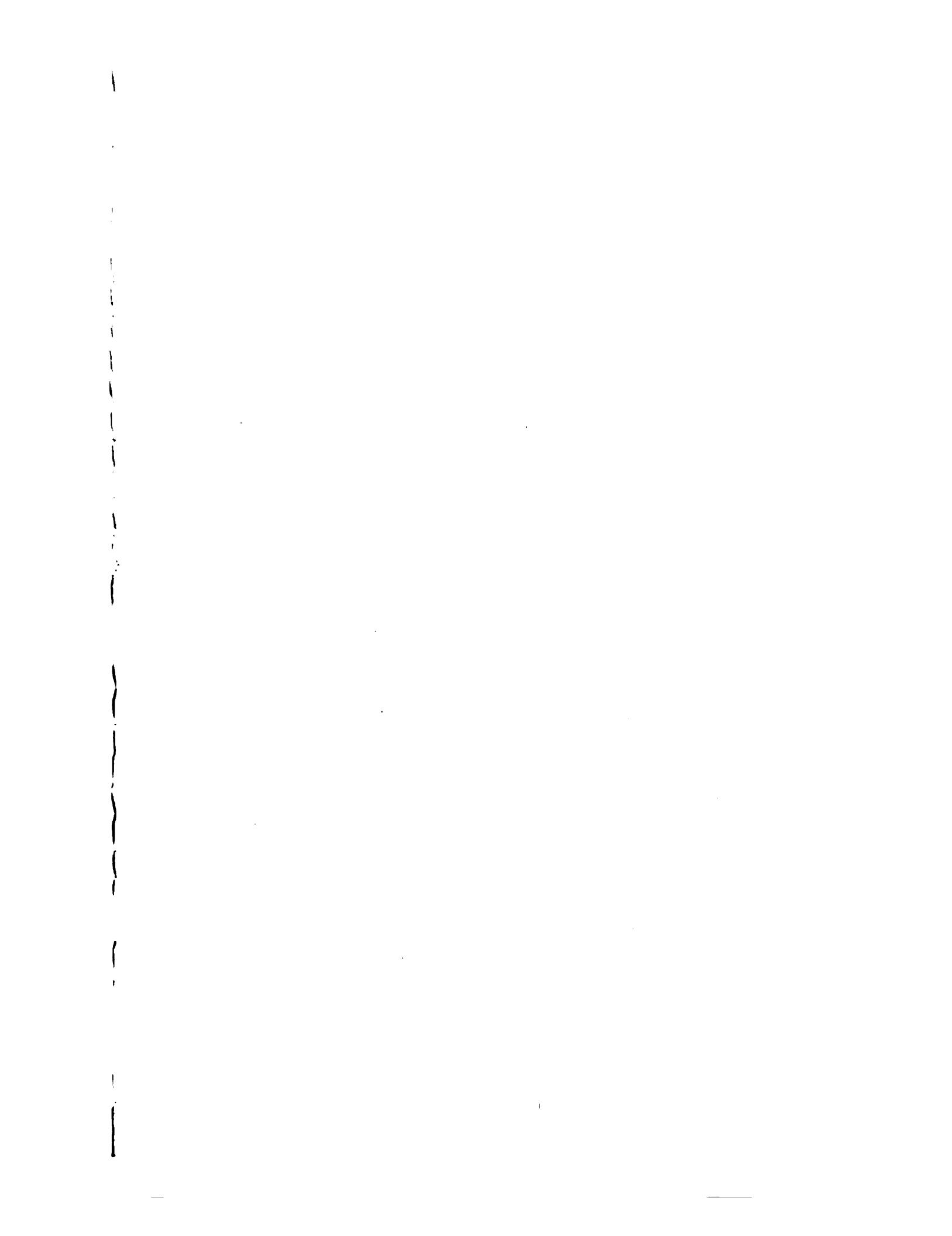
CASE OF MYCOSIS OF THE SOFT PALATE.

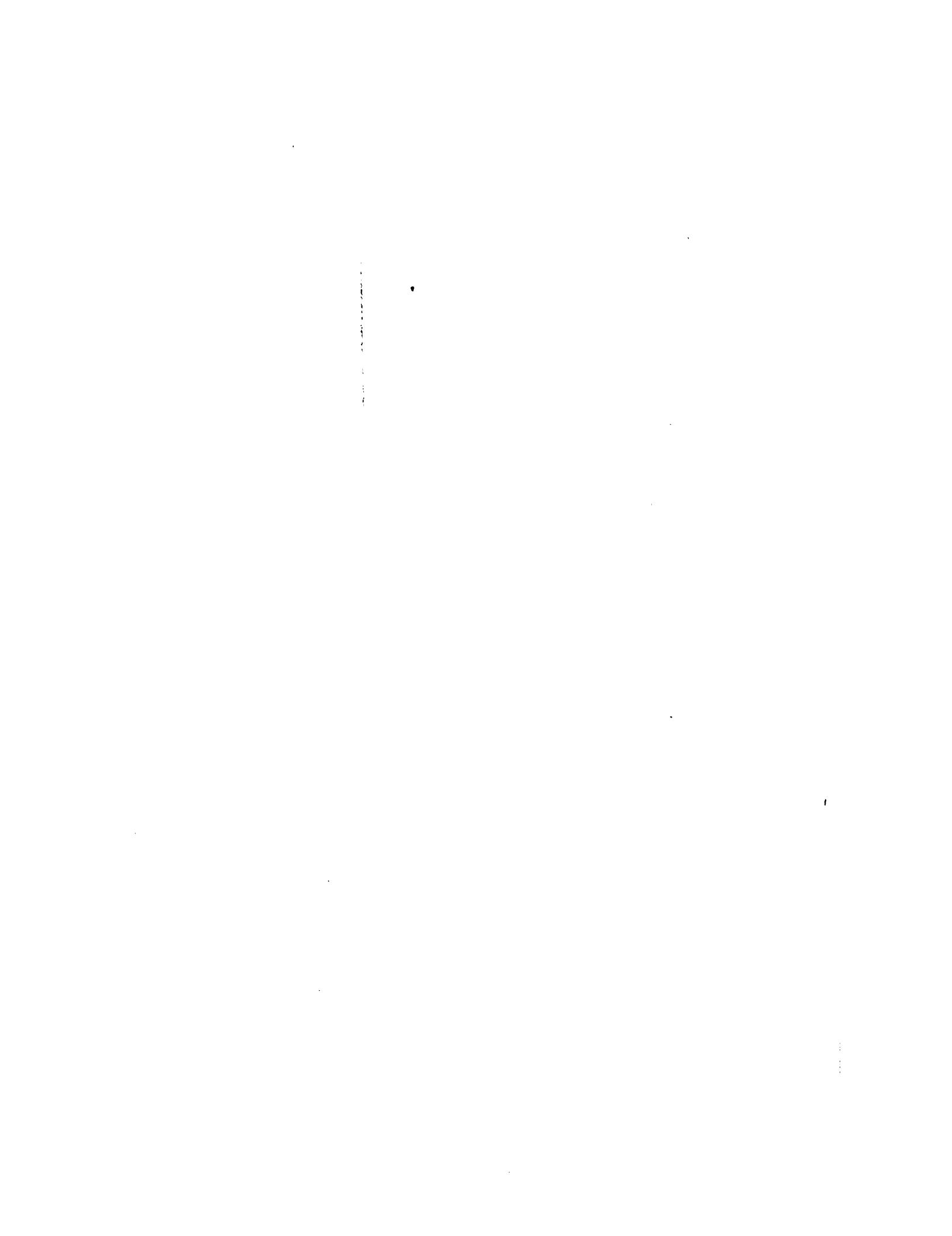
Shown by Dr. HERBERT TILLEY. Male, aged forty-two, with an area of inflamed mucous membrane on the soft palate immediately

above the right tonsil—the area referred to is covered with what appear to be some twenty pustules about the size of a hemp seed. Patient complains of some pain in swallowing, or when the tongue is depressed. There is no history or signs of tubercle or syphilis in other parts of the body. Symptoms have been present for seven months.

The PRESIDENT thought the appearance was allied to that of the condition called leukoplakia ; the formation in small, isolated spots he had found not uncommon on the palate. The condition, he thought, might have a syphilitic basis. He had seen this condition on the mucous membrane beyond the margin of an epithelioma, and though this condition might exist for some years, he thought it was better to remove the mucous membrane in the present case in view of the possibility of an epithelioma developing.

Mr. STUART Low said he had come to the conclusion that this was a case of epithelioma. The patient complained of pain on swallowing, on palpation through the mouth the pain was considerable, and a certain amount of induration could be felt.





PROCEEDINGS
OF THE
LARYNGOLOGICAL SOCIETY OF LONDON.

ONE HUNDRED AND SEVENTH ORDINARY MEETING, *June 1, 1906.*

CHARTERS J. SYMONDS, F.R.C.S., President, in the Chair.

HENRY J. DAVIS, M.B.
W. JOBSON HORNE, M.D. } Secretaries.

Present—18 members and 4 visitors.

The minutes of the previous meeting were read and confirmed.

The following gentlemen were elected as ordinary members—

JOHN DAVIS LITHGOW, M.B., C.M., F.R.C.S. Edin.
DUNCAN MATHESON MACKAY, M.D., C.M. Edin.

REPORT OF MORBID GROWTHS COMMITTEE.

(1) Dr. Brown Kelly's specimen of Hyperplasia of the Uvula, shown December, 1905. The Committee agreed with this description.

(2) Mr. Stewart Low's specimen of Naso-pharyngeal Growth, shown February, 1906. The Committee considered the specimen to be one of carcinoma.

The following communications were made :

CASE OF INOPERABLE CANCER OF THE FAUCES, THE PHARYNX, THE TONGUE, AND THE CERVICAL GLANDS THAT HAS SHOWN MARKED AMELIORATION AFTER TREATMENT FOR TEN WEEKS WITH A BACTERIAL VACCINE OF NEOFORMANS.

Shown by Dr. SCANES SPICER. The patient, a Balaclava veteran, aged seventy-five, was sent to the Throat Department of St. Mary's Hospital in March, 1906, by Dr. W. T. Evans for an ulcerating growth in the throat and enlarged glands in the neck. The tumour occupied

the site of the left tonsil, the faucial pillars, the side of the tongue, and extended down the wall of the pharynx. It blocked the faucial isthmus sufficiently to prevent laryngoscopy even with the smallest mirror, but there was no affection of phonation or respiration. The tongue could not be extruded. The surface of the growth was studded with bloated fungous granulations imbedded in copious brownish-yellow foetid fluid on an ulcerated purplish base; there was a large mass of swollen hardened glands behind the angle of jaw. There was considerable dysphagia and much pain in the left side of the head and the ear, on trying to swallow. He had lost much weight lately but could not say how much. The case was diagnosed as malignant and inoperable—a view in which Mr. A. J. Pepper concurred. A portion of the growth was removed from the tonsillar area. Iodide of potassium, gr. xv three times a day, and an antiseptic gargle were given for a week. As no improvement was observed this was stopped; and the Pathological Department having reported that the growth was a spheroidal-celled carcinoma, the patient was sent to the Inoculation Department with a view to treatment by a bacterial vaccine by Professor A. E. Wright. This was carried out as shown by the accompanying chart indicating the doses, intervals of injection, and the opsonic reaction of the blood. The condition of the fauces and the glands was regularly and carefully observed by Dr. Scanes Spicer. The favourable changes commenced at once and continued to increase for five or six weeks, after which there was no further improvement, but no regression. The patient lived at home, and walked to the hospital for treatment. The changes observed were—(1) diminution in the size of the faucial mass, so that laryngoscopy became possible; (2) lessening of the ulcerated surface, and the unhealed part looking like a healthy granulating surface; (3) disappearance of the bloated granulations; (4) loss of fœtor; (5) disappearance of dysphagia and pain in the throat; (6) the tongue became less rigid; (7) the external mass shrunk down enormously, leaving one small hard gland. No other treatment was used. Whenever the opsonic power was low the patient invariably complained more of head pains. No opinion was tendered as to whether the treatment had influenced only secondary ulcerative and septic processes or the malignant substratum itself, nor did it seem determinable what were the proportions which these factors bore in the sum total locally. The whole improvement was nevertheless marvellous both locally and in the patient's general condition, and the case was of good augury for the in-

fluence of the method. A cure was not claimed, and the patient was shown as still under treatment in case unfavourable changes should supervene before next session. The clinical record was incomplete, but the history and stigmata of syphilis were negative.

The PRESIDENT said he had been much struck by the condition of the part at the present time; it was so clean and free from odour, and from the description of the condition given by Dr. Scanes Spicer, they were able to appreciate the value of the treatment.

REMARKS EXPLANATORY OF THE TREATMENT.

By PROFESSOR A. E. WRIGHT, F.R.S.

PROFESSOR A. E. WRIGHT said that he had gladly come in response to Dr. Scanes Spicer's invitation to explain to the Society the rationale of what had been done in connection with the treatment of this case.

Dr. Doyen, as was well known, had asserted that there could be obtained by culture from all, or practically all, new growths—whether of a malignant or a non-malignant nature—cultures of a characteristic microbe. This microbe was, by Doyen, regarded as the specific cause of cancer on the ground that it produced in his hands when inoculated into rats neoplastic lesions. It was accordingly named by Doyen the *Micrococcus neoformans*. While those who have seen Doyen's sections of the lesions obtained by him in rats by the inoculation of cultures of his *Micrococcus neoformans* do not, so far as I know, agree in the view that the lesions he produced were of the nature of new growths, there can be no doubt of the singularity of the pathological changes which are here in question. In specimens given to me by Dr. Doyen the whole upper lobe of the rat's lung has been converted into a mass of cartilage. Here and there through the rest of the lung are scattered large masses of embryonic cells—perhaps only scar-tissue. Interspersed with these are masses of epithelial tissue somewhat resembling adenomata—possibly only large epithelium-lined diverticula taking origin from the bronchi. However this may be, Metchnikoff first, and after him many others—including some of my fellow-workers at St. Mary's Hospital—have confirmed Doyen's statement that a characteristic microbe—the *Micrococcus neoformans* can be obtained by culture from tumours. The microbe in question has a superficial resemblance to the staphylococcus. It differs from it, however, in the following particulars:

- (1) When first taken from the body it gives only very sparing cultures on ordinary agar.

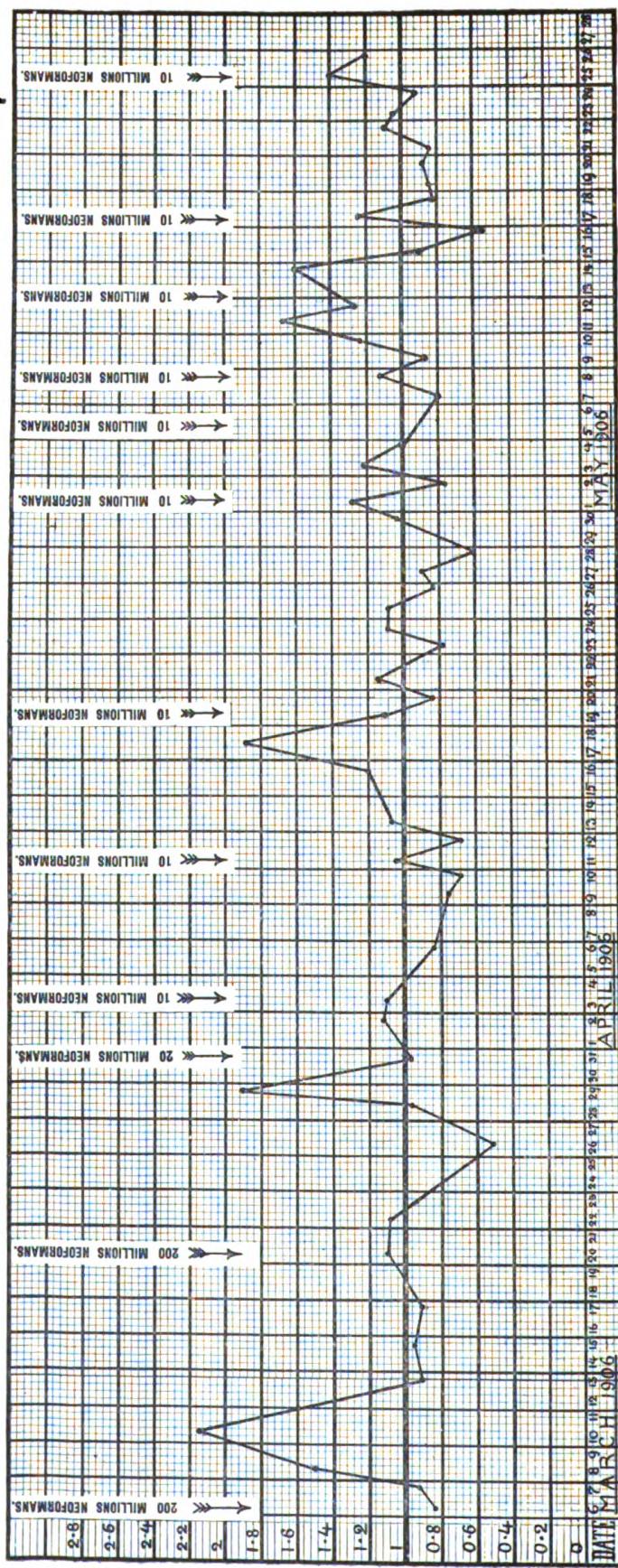


Chart to illustrate Professor Wright's remarks explanatory of the treatment of Dr. Scanes Spicer's case of inoperable cancer of the fauces.

(2) In film preparations it is arranged, not in clusters like the staphylococcus, but in short chains, and in particular in Y-shaped figures—*i. e.* in short bifurcating chains.

(3) It is agglutinated by normal human serum,¹ even when this has been diluted two hundred or more times.

(4) The *Micrococcus neoformans* can be further differentiated from the staphylococcus by the fact that a blood which possesses—whether as a result of artificial or auto-inoculation—a high opsonic power with respect to the *Micrococcus neoformans* may possess a low opsonic index with respect to the staphylococcus; and *vice versa*.

A scientific basis for the differential diagnosis of the *Micrococcus neoformans* having thus been obtained, and having verified by these means that a culture of the *Micrococcus neoformans* supplied by a Belgian observer—Geets—corresponded in all respects with two cultures² obtained by us at St. Mary's; we have recently begun to address ourselves to the task of investigating the opsonic and agglutinating power of the victims of malignant disease with respect to the *Micrococcus neoformans*.

It will suffice to say with respect to the agglutinating and opsonic powers of the victims of malignant disease that these differ from the normal (1) in the fact that they are lower and in others much higher; (2) in the fact that the opsonic index is in some cases constantly fluctuating as it does in cases of bacterial infection which are associated with constitutional disturbance; and (3) in the fact that phagocytosis is in some cases obtained with the serum after it has been heated to 60° C. for ten minutes. We have here, it seems to me, ground for concluding that infection by the *Micrococcus neoformans* is one of the factors which must be reckoned with in connection with malignant disease.

The case Dr. Scanes Spicer has shown to you is one of a first batch of five cases in connection with which we have undertaken inoculations with a vaccine consisting of a sterilised and enumerated culture of the *Micrococcus neoformans*.

¹ The fact that some of his cultures of the *Micrococcus neoformans* were agglutinated by normal serum is incidentally noted by Karwacki (*Centralblatt für Bakteriologie*, vol. xxxix, (Originale), p. 369, 1905) as a complication which presents itself in connection with the appreciation of the value of the agglutination obtained by him with the blood of cancer patients. The fact that the *Micrococcus neoformans* is agglutinated by every normal human serum while the staphylococcus is not so agglutinated appears to have been overlooked by this observer.

² The first of these cultures was obtained by Dr. Loveday from the interior of a breast amputated for carcinoma, the second by Dr. May from the discharge from an ulcerated surface of an epithelioma in the glands of the neck, secondary to epithelioma of the tongue.

It is the only case in which we have had a striking result. Of the other four cases two have already died. Of the two others one appears to be quite stationary, while the other shows marked signs of improvement.

The PRESIDENT said the members had already shown their appreciation of Dr. Wright's lucid though brief account of the method he had adopted in the case and the progress of the investigation up to the present. They would agree that no one was better qualified to extract whatever was of good in the method than Professor Wright.

A CASE OF INFILTRATION OF THE LEFT VOCAL CORD.

Shown by Mr. H. BARWELL. The patient, a male nurse, aged fifty-three, had been suffering from hoarseness and frequent aphonia for eleven months, and much pain on swallowing solids for four months; there was slight inspiratory stridor. There was some frothy expectoration, with occasional small streaks of blood. Examination of the chest revealed bronchial breathing and increased vocal fremitus and resonance over the entire upper lobes of both lungs, but the physician who examined him did not consider the signs distinctive of phthisis. The left cord was occupied for its anterior two thirds by a dark red, papillary swelling; the posterior third was red, the cord was fixed near the cadaveric position, and the left arytenoid was slightly swollen, having the appearance of inflammation about the joint rather than tuberculous infiltration; there was a small excrescence in the interarytenoid space to the right of the middle line. There appeared to be some subglottic swelling extending across the anterior commissure to the right side.

The patient had only been examined once in the out-patient room; his sputum had not been examined nor had a temperature chart been kept. Mr. Barwell thought the case might interest members from the point of view of laryngoscopic diagnosis and he desired opinions on the subject.

Mr. CRESSWELL BABER said he thought there was ulceration, and that the prominence on the left arytenoid was the edge of an ulcer. If antisyphilitic treatment had not yet been tried, he recommended that it should be ordered.

Dr. STCLAIR THOMSON regarded the case as distinctly one of tubercle, because of the infiltration of the interarytenoid, the prominent mammillary surfaces, and the great loss of part of the vocal cord and the adjoining ventricular band.

Mr. BARWELL, in reply, said he refrained from expressing an opinion, but he had so far committed himself as to arrange to take the patient into the Mount Vernon Hospital for Consumption.

A CASE OF PALATAL TUMOUR OF TWENTY YEARS' DURATION.

Shown by Dr. J. W. BOND. The patient was a woman aged sixty-five. The tumour first appeared twenty years ago, and was a small warty growth. Twelve years ago it was operated upon at the London Homœopathic Hospital. The growth remained absent for eight years. Since then it has been growing until it has reached its present size. There was never any pain until lately. There had been considerable hæmorrhage during the last few weeks. The patient was getting very weak. The disease extended into both nostrils. There had been considerable blood and watery discharge from the nostrils lately. The maxillary antra were both absolutely dark. No glands could be felt in the neck. The pain had been greatly relieved by iodide of potassium, 5 grs. three times daily.

No microscopical specimen of growth was shown, nor had the diagnosis been obtained of the tumour that was removed.

The PRESIDENT thought it must be a large sarcoma; it was evidently not an epithelial new growth.

A CASE OF EPITHELIOMA OF THE TONSILS.

Shown by Dr. E. A. PETERS. The patient, an old soldier, aged fifty-five, when seen in June, 1905, for two months had been aware of a lesion which appeared as a round ulcer half an inch across situated on the right tonsil and anterior pillar. Microscopical evidence indicated epithelioma. The ulcer improved slightly under iodide of potassium and then relapsed.

July 6, 1905.—Through an incision along the sternomastoid a few glands were removed which appeared quite healthy; the external carotid was then tied.

July 13, 1905.—Ten c.c. of antistreptococcal serum were injected and the patient anæsthetised and placed in the Trendelenburg position with extended neck. A preliminary laryngotomy was carried out and the pharynx plugged with a soft sponge. The cheek was split and the soft palate was divided. An incision beyond the margin of the œdema was made, the pharyngeal wall was separated from its connections, with the tongue, hard palate, and mandible. The bone immediately under the œdema was chiselled away. Finally the mucous membrane was brought together. There was very little bleeding. The patient's bed was raised by placing the foot on two chairs. The plug and tube were removed two hours later. There was present a slight recurrence in the scar and an enlarged gland.

The PRESIDENT congratulated Dr. Peters upon the clean sweep which he had made so far. He thought some further operation was justified. The inability to open the mouth he regarded as a result of the scar. He recommended a freer operation in the sub-maxillary and cervical regions, which, combined with a further removal of the growth in the mouth, offered good prospects.

Mr. BETHAM ROBINSON suggested that Dr. Peters should divide the jaw, by which he would not only secure good mobility, but would get satisfactorily at the ulcer.

FUNCTIONAL APHONIA IN A SOLDIER AFTER AGUE.

Shown by Dr. E. A. PETERS. The patient, aged twenty-five, lately in the 13th Hussars, was in the South African campaign for two years, with only one month in hospital.

On February 19, 1905, while in India he was thrown from a horse and one month later was admitted for a severe attack of "ague" which lasted about fourteen days; an attack of convulsions resulted in complete paralysis of all the limbs without bladder trouble. Aphonia set in at the same time.

In March, 1906, on examination there was complete aphonia. The pharynx and larynx were nearly insensitive. On attempted phonation the vocal processes flicked together, but the cords were lax. During respiration the cords were widely abducted, while there was only a suspicion of movement.

In May the patient twisted his ankle and recovered his voice.

CHRONIC OSTEITIS OF THE FRONTAL BONE WITH CHRONIC SINUSITIS.

Shown by Dr. E. A. PETERS. The patient was a road-sweeper aged forty-one. Three years ago a radical cure of the left maxillary antrum was carried out, with removal of the outer wall of the inferior meatus for chronic empyema. Extensive pyorrhœa alveolaris was present; this had never subsided.

In January, 1905, he suffered with headache, and an abscess presented beneath the right supra-orbital margin. This remained open.

In June, 1905, he came to hospital. There was a little pus in either side of the nose, but no collection in the left antrum.

Dr. Peters explored the right frontal sinus region, but could find no sinus or infundibulum. He scraped a considerable amount of softened diploe away at this spot and also beneath the suppurating abscess tract.

In May, 1905, there was pus in both sides of the nose and a

probe did not pass above the orbital margin on the right side. On the left side a probe entered into a large frontal sinus which was full of pus. There was no external swelling or pain.

The PRESIDENT said the patient seemed to have suppuration on both sides of the nose, and he thought there must be a frontal sinus somewhere on the right side, possibly small, and a fairly large one on the left.

Dr. STCLAIR THOMSON said he had a very similar case to the present one, which gave him a good deal of trouble. The patient had chronic sinusitis in most of the cavities of the head, and evidently had had an acute attack, with swelling over the right orbit. This was lanced in the country, ran an indefinite course, and came with a sinus similar to that in Dr. Peters' case, but farther out. The frontal sinus was full of pus and polypi, but it did not communicate with the fistula in question; it was a fronto-ethmoidal gallery, which ran out over the top of the orbit. He thought the present case was one of suppuration of one of the accessory cavities, probably the frontal, and of the ethmoidal cells. He had already suggested to Dr. Peters that if he did practically a Killian flap—making the flap from the middle line on to and below the inner canthus—he would get freely into the ethmoidal cavity, and would no doubt reach the bottom of the suppuration. His own case would be published next month, with photographs. It gave him much trouble because he had not at first been bold enough. His patient got well.

FIXATION OF THE LEFT VOCAL CORD IN THE CADAVERIC POSITION, MOST PROBABLY DUE TO ADHESIONS FIXING AND DRAGGING ON THE RECURRENT LARYNGEAL NERVE.

Shown by Mr. STUART Low. He had shown this case as the condition, especially in a young woman, was uncommon, and the cause unusual. The patient was a young woman aged nineteen, and she came to the Central London Throat and Ear Hospital complaining of failure of the voice on speaking for any length of time. This had been present for six months. She had been under her doctor, but had not benefited by the treatment.

There was a history of severe rheumatic fever eight years ago, and she had had at intervals since repeated recurrences of rheumatic pains in her joints.

Examination of the larynx showed the left vocal cord completely fixed in the cadaveric position. The opposite cord came over and approximated well to the left vocal cord on phonation. The voice was of pure, low-pitched tone and there was no intermittent hoarseness.

Examination of the chest revealed the following: There was mitral regurgitation and considerable enlargement of both right and left ventricles. This, however, probably did not in itself account for the very great cardiac enlargement. On the other

hand, pericarditis leading to adhesions was a frequent complication of rheumatic endocarditis in childhood and was a recognised explanation of some of the marked cardiac enlargements which are met with in early life. The probability therefore was that a condition of pericardial adhesion was present.

Pericarditis was mentioned by several writers as a cause of laryngeal paralysis. There was presumptive evidence of pericardial adhesions. Such adhesions may be responsible for a laryngeal paralysis. Therefore in all probability the paralysis present in this case was the result of pericardial inflammation and consequent thickening and adhesions to the neighbourhood of the recurrent laryngeal nerve as this looped backward under the aortic arch.

Dr. H. J. DAVIS said he thought Dr. Atwood Thorne last year showed a case of the same kind, and it was thought to be probably due to left auricular dilatation. The skiagram now shown was suggestive of a dilated left auricle pressing on the recurrent laryngeal nerve. Adhesions forming in the pericardium in pericarditis was common, but he did not remember to have seen a case where the adhesion was said to have dragged on the recurrent laryngeal nerve and caused paralysis. He thought the present patient was more likely to have a dilated left auricle as a result of mitral disease with consequent regurgitation. She was able to talk well, and the right cord swung over to meet its fellow. There was no dilatation of pupil on either side, as was present in Dr. Atwood Thorne's case. In a severe attack of pericarditis there was myocarditis and endocarditis as well, for there was only the thickness of the myocardium for the inflammation to spread through.

Mr. BARWELL said that a dilated left auricle was commonly given as a cause of paralysis of the recurrent laryngeal nerve; but he had not heard adhesions mentioned before. He believed cases had been reported in which the nerve had been compressed by massive pericardial effusion. A similar case was recorded in the *Archives Internationale*, in which paralysis of the recurrent laryngeal on the left side followed a right pneumothorax. In that case the suggestion made was that there was positive pressure in the right pleura, which pushed over the arch of the aorta and dragged on the recurrent laryngeal. Therefore apparently various changes in the chest might give rise to that paralysis, and it became a matter of conjecture as to which was operating in a given case.

Mr. STUART Low, in reply, said it was considered doubtful whether the shadow in the skiagram represented the left auricle. Physicians said they could not depend on it. There was dragging on the chest-wall, which was thought to be due to pericardial adhesions; if the patient had been stripped and lying on a couch, that dragging would have been very obvious. Moreover, the distress of the patient on exertion was far more than would be accounted for by hypertrophy of the organ. The hypertrophy of the heart was thought to be due to the effort of that organ to overcome the adhesions.

ANNUAL GENERAL MEETING, June 1, 1906.

CHARTERS J. SYMONDS, F.R.C.S., President, in the Chair.

The minutes of the last Annual General Meeting, held on January 12, 1906, were read and confirmed.

Mr. Stuart Low and **Mr. Harold Barwell** were appointed scrutineers of the ballot. The following were elected Officers and Members of the Council for the ensuing year:

President—J. B. Ball, M.D.

Vice-Presidents—F. Willcocks, M.D., Charters J. Symonds, F.R.C.S., William Hill, M.D., P. Watson-Williams, M.D.

Hon. Treasurer—H. B. Robinson, F.R.C.S.

Hon. Librarian—StClair Thomson, M.D.

Hon. Secretaries—H. J. Davis, M.B., W. Jobson Horne, M.D.

Council—Sir Felix Semon, K.C.V.O., M.D., Philip de Santi, F.R.C.S., J. Middlemass Hunt, M.B., S. Paget, F.R.C.S., Atwood Thorne, M.B.

Mr. H. B. Robinson submitted the Treasurer's Report and Balance Sheet, which were read and unanimously adopted.

BALANCE SHEET, SESSION 1905-1906.

INCOME.		EXPENDITURE.
Balance, January, 1906	£ 1 14 0	Rent 21 0 0
Subscriptions	118 13 0	Expenses of Amalgamation
Entrance Fees	3 3 0	Scheme 3 0 5
Interest on Deposit	1 7 6	Adlard—Printing 12 3 6
		Baker—Microscopes 0 5 1
		Creswick—Receipt Book 0 7 6
		Martindale 0 13 3
		Porters' Christmas Boxes 1 0 0
		Bank Charges 0 0 9
		Secretaries' Expenses 1 12 11
		Treasurer's 0 15 11
		<hr/> 40 19 4
		Balance 83 18 2
	<hr/> £124 17 6	<hr/> £124 17 6

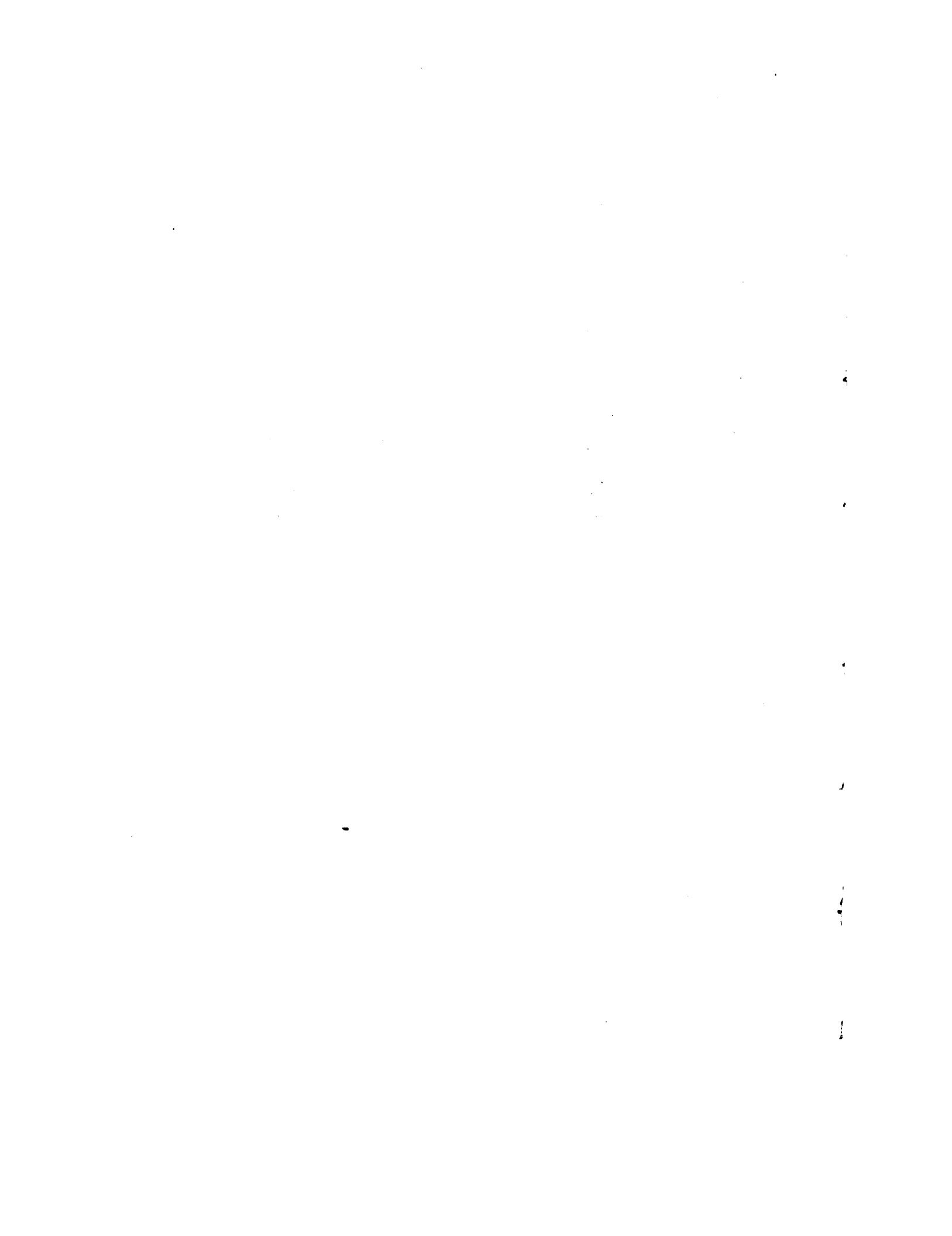
Deposit at Banker's (London Joint Stock Bank)—£150.

Examined vouchers and found correct,

H. FITZGERALD POWELL,
ATWOOD THORNE, } Auditors.

June 1, 1906.

HY. BETHAM ROBINSON, Hon. Treasurer.



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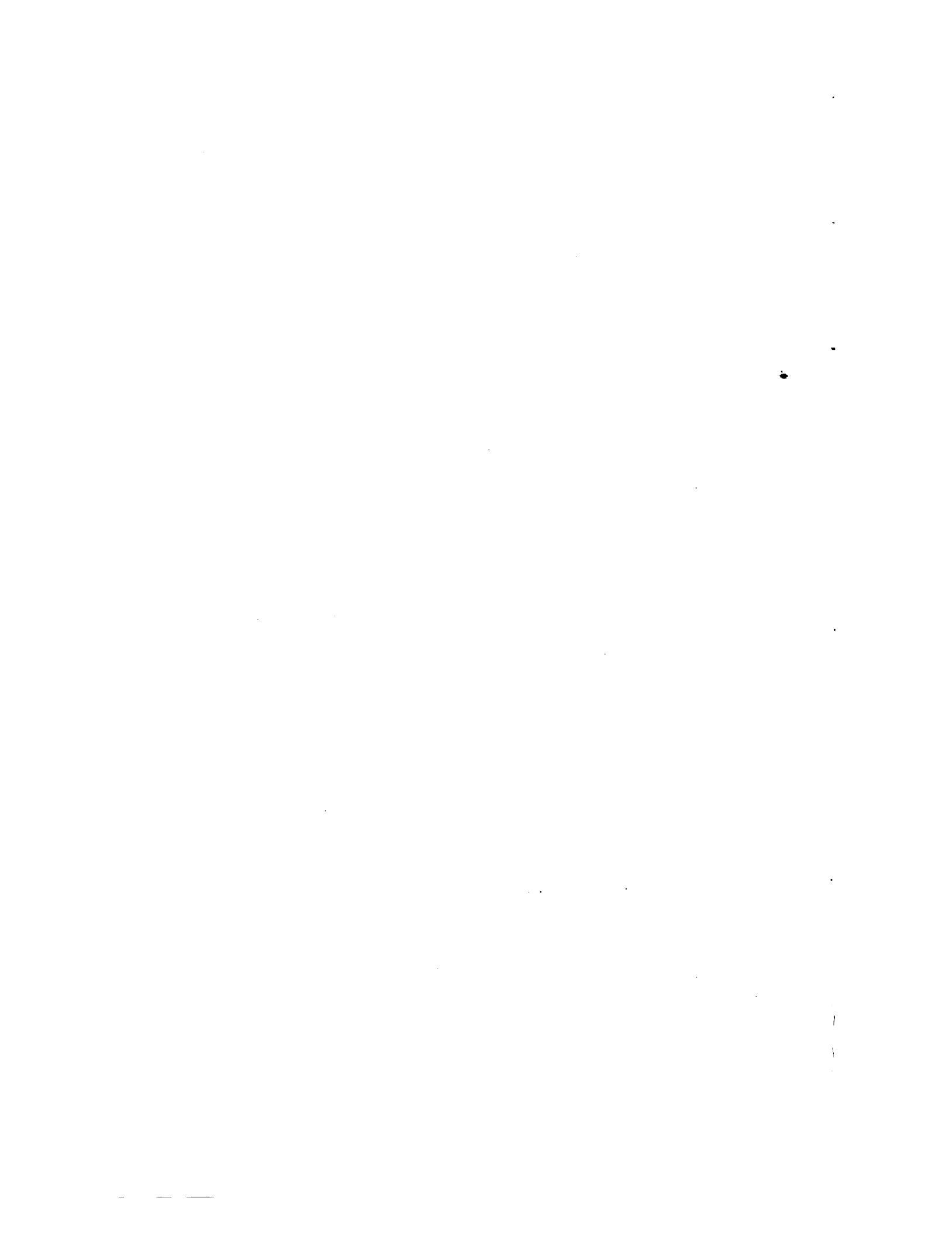
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OF
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1907.



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JUNE 1ST, 1906.



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PROCEEDINGS OF THE LARYNGOLOGICAL SOCIETY OF LONDON.

One Hundred-and-eighth Ordinary Meeting, November 2, 1906.

J. B. BALL, M.D., *President, in the Chair.*

HENRY J. DAVIS, M.B. }
W. JOBSON HORNE, M.D. } Hon. Secretaries.

Present—40 members and 5 visitors.

The minutes of the previous meeting were read and confirmed.

The following communications were made :

TUMOUR OF THE PHARYNX.

Shown by Dr. J. B. BALL. He said : The patient, a woman, aged fifty-three, first noticed a swelling in the left side of the throat, about five years ago. Previous to this she says that some gritty matter came from the left tonsil on several occasions. The swelling increased very slowly at first, but during the last twelve months it had increased more rapidly. On the left side of the throat is a tumour, about the size of a tangerine orange, pushing forwards the soft palate, which is tightly stretched over it. The tumour is of solid consistence, slightly elastic on pressure. On the external surface, just behind the ramus of the lower jaw, there is a distinct hard swelling, apparently continuous with the tumour inside. She has no pain, and only a little difficulty in swallowing food, and slight difficulty with her breathing occasionally at night.

Mr. BUTLIN said that he had only been able to make a short examination of the patient, but that he felt sure there was a tumour deep down behind the angle of the jaw. There could be little doubt that the tumour was continuous with the tumour of the palate, both on account of its hardness and its absolute immobility. He thought he had had a similar case about a year ago. A gentleman was sent to him by Professor von Bergmann with a hardness in the left side of the palate, which felt like a diffuse new growth. Mr. Butlin divided the palate in the middle line, made an incision into the tumour, let out a little fluid, and finding no tumour behind the palate, he closed the incision and hoped that was an end of the case. But within a few weeks the patient returned, complaining of discomfort in the mouth and deep down in the neck. As there was a swelling over the lower part of the parotid gland, which felt like a soft

lymphatic gland, an operation was performed from the outside. Even then the real disease was almost overlooked, for it was a hard tumour which lay right beneath the whole thickness of the parotid gland, well-defined, enclosed in a thin capsule and lying up against the base of the skull. It was quite white on section and cut like a very firm potato. It was completely enucleated, and proved to be a typical endothelioma. Mr. Butlin advised that a similar operation should be performed in the present case.

Dr. DUNDAS GRANT said he had had two cases which much resembled the present one, and in both he was able to shell out the tumour by an incision through the anterior half of the palate. In the first he thought he would have much difficulty, and went to it in the country with galvano-cautery, snares, etc.; but after making an incision through the palate with scissors he was able to shell it out quite well. The second case was very similar. They seemed like the tumours described by Paget in his well-known paper.

Mr. E. W. ROUGHTON said he had seen a tumour in a similar position and it shelled out easily by an incision through the mucous membrane. He recommended that the case should be dealt with from inside rather than from outside the mouth.

Dr. FITZGERALD POWELL thought the tumour was attached to the angle of the jaw. On palpating the growth in that situation there appeared to be considerable tension, as if it was connected with the jaw. It looked rather like a fibro- or adeno-sarcoma. He thought the Society would be indebted to Dr. Ball if he would furnish a further account of the case if the tumour were removed.

Dr. BALL, in reply, thanked members for their opinions. He would report further if the patient agreed to operation.

SWELLING OF THE LEFT ARYEPIGLOTTIC FOLD.

Shown by Dr. J. B. BALL. He said: The patient, a man aged fifty-seven, complains of discomfort in the throat, and of feeling a lump, which he tries to dislodge by frequent swallowing. He has had these feelings for about three months. There is no actual pain, and the voice is not materially affected. He has had good health, except for an occasional attack of bronchitis in the winter. There are no physical signs in the chest and no albuminuria. On examination of the throat the lateral folds of the pharynx are seen to be thickened, and these thickened folds are continued down to the level of the larynx in the form of two symmetrical and very prominent swellings at each side of the posterior pharyngeal wall. There is a pale, oedematous, and somewhat pear-shaped swelling involving the aryepiglottic fold and arytenoid on the left side. The left vocal cord is largely concealed by the swelling, but is not fixed. He has been under observation for three weeks, during which time he has taken 10 grains of iodide of potassium three times a day. No change has been observed in the condition.

Dr. DUNDAS GRANT said he believed it to be chronic œdema, of which several cases had recently been shown before the Society. Their nature seemed to be very obscure. There was a suggestion that it might be lymphomatous.

Mr. H. BARWELL agreed that it was probably chronic hyperplasia. The lateral bands of the pharynx presented very much the same swollen aspect as did the arytenoid, and that would be strongly suggestive of this condition.

Dr. JOBSON HORNE considered that the swelling over the arytenoid was largely due to œdema. He once had the opportunity of observing both clinically and also *post mortem* a precisely similar case. At the autopsy the œdema was purely local, and beneath it, in the fold running down between the cartilages of Santorini and Wrissberg, there was a slight abrasion—in fact, a small ulcer. There was some slight necrosis of the underlying cartilage. There was no tubercle nor evidence of any other disease in the larynx. Death occurred, not from the laryngeal affection, but from chronic interstitial nephritis. The movement of the vocal cord in this case negatived any very deep seated disease of the arytenoid cartilage.

PAPILLOMATA IN THE NOSE.

Shown by Dr. BALL. He said : The patient is a woman aged fifty, who has complained for some months of obstruction in the left side of the nose. There has been no discharge from the nose, nor any bleeding. Several warty growths are seen implanted on the septum, floor, and inferior turbinal, in the anterior region of the left nasal fossa.

Mr. HERBERT TILLEY suggested the advisability of removing the anterior end of the turbinal and cutting sections of the growths. The one on the inferior turbinal he thought might be in the nature of granulations round an ulcer, possibly tubercular. The procedure he suggested would settle the diagnosis.

Dr. PEGLER asked whether the case had had any treatment, and if any of the growth had been removed, from which part, also had the specimen been preserved.

Dr. BALL, in reply, said he had had suspicions that there were some granulations. She came three months ago, and a couple of the warty growths were snared off. He thought Dr. Tilley's suggestion was possibly correct. There had been no treatment beyond removal. The specimen was not preserved, but to the naked eye it was a wart-like growth. In reply to Dr. Milligan, he would inquire about syphilis ; he had not suspected it.

THIMBLES FOR MAKING ASEPTIC WOOL MOPS.

Mr. CRESSWELL BABER showed metal thimbles fitting on to the left forefinger and thumb, with which wool can be easily wound round a cotton carrier. They are grooved on the opposing surfaces and have small handles by which to hold them. They are sterilised by boiling.

The PRESIDENT said it was difficult to judge as to the usefulness of the thimbles until one had used them for a time, but if they could be easily manipulated they would be very helpful. It was often impossible to keep one's fingers absolutely clean, and he thought these thimbles might be useful, especially in ear work.

Dr. DUNDAS GRANT said the thimbles acted very well indeed.

BILATERAL TUBERCULOUS LARYNGITIS, COMPLETELY HEALED FOR THREE YEARS, WITHOUT LOCAL TREATMENT, IN A MAN AGED FIFTY-FIVE.

Shown by Dr. STCLAIR THOMSON. This patient consulted me first on August 10, 1899, when he weighed 10 st. 10 lb.; to-day he weighs 13 st. 2 lb. In 1899 there were symptoms at the right apex, and his sputum contained tubercle bacilli in considerable numbers. The left cord showed irregular granulations on its posterior third, a slight infiltration of the corresponding part of the right cord. In 1900 he had a long attack of pleurisy, and his chest and laryngeal symptoms became more marked. In 1901 there was infiltration of the interarytenoid region, injection and infiltration of the right cord with sub-cordal thickening, and the left vocal process was concealed with ulcerating infiltrations.

I did not see him again for nearly two years. On May 21, 1903, I found his larynx intact except for some slight interarytenoid thickening, and with white scars over and below both vocal processes. His larynx was seen by Sir Felix Semon and Dr. Watson Williams on November 7, 1903, both of whom agreed that there was nothing amiss with it. To the latter I am indebted for the sketch he then made showing the site of the scars. I have only to add that the patient's "cure" has been carried out in Plumstead, where he shares his bed with his wife, and until I converted him he had a dread of fresh air.

EXTENSIVE TUBERCULOUS LARYNGITIS, NO LOCAL TREATMENT, COMPLETE HEALING CAUSING STENOSIS OF THE GLOTTIS AND REQUIRING TRACHEOTOMY, HEALING MAINTAINED SINCE ONE YEAR, IN A WOMAN AGED FORTY.

Shown by Dr. STCLAIR THOMSON. The husband of this patient died in 1900 of phthisis. She first attended me on March 25, 1904, for hoarseness and marked dysphagia. There was oedema-like infiltration of both arytenoids, mamillary thickening of interarytenoid fold, and some sub-glottic infiltration on the left side. Fortunately, I can hand round the rough sketch which I made at

the time. The left upper lobe was dull and there were moist sounds. The sputum was scanty and no tubercle bacilli were ever found. She was put upon general and hygienic treatment. The condition had become more marked in July, and throughout 1904 there was increased œdema of arytenoids and ulceration of the interarytenoid region. In June, 1905, it was noticed that there was impaired abduction of the cords, but that they were clear, while the interarytenoid fold was less thickened and the posterior surfaces of the arytenoids were losing their œdema-like look. In November, 1905, there was no dysphagia. The voice was clear and fairly good. For two or three months the stridor at night was heard all over the house, and it was marked even when at rest. At this time it was noted that the appetite was poor, the temperature 98° F., and dulness and moist râles on the left upper lobe, with dulness and tubular breathing at the right apex. The vocal cords were then fixed, so that while they adducted easily the amount of abduction left only a small chink. A low tracheotomy under cocaine had, therefore, to be done on February 1, 1906. Since then the patient has gained in weight, and I have gradually, but with great difficulty, converted her to believe in fresh air, exercise, and rest, while diminishing her faith in over-clothing. She breathes freely, the voice is clear, there is no stridor. The larynx is completely cicatrised. Both vocal cords possess slight movement, but this is evidently limited in action by cicatricial tissue. The glottis is reduced to a slit. The arytenoids, and, in fact, the whole larynx, is otherwise quite normal.

The spontaneous healing of such a well-marked case of tuberculous laryngitis is extremely noteworthy, and that it should result in such glottic stenosis as to require tracheotomy is, I imagine, a most exceptional occurrence. The possibility of the infection being mixed with syphilis occurred to me, but neither the history nor the appearances at any time supported such a possibility.

The PRESIDENT said that in the case he examined the lesions had healed so completely that one would not have thought any tuberculous disease had ever been present. Both cases showed that tuberculous laryngitis would get well without any local treatment.

Mr. H. BARWELL said he saw only the second case, but the Society was much indebted to Dr. Thomson for insisting on the value of rest to the larynx in such cases. He did not know whether the voice was absolutely rested in those cases, but rest certainly was important. In the second case there still appeared to be a little infiltration at the back of the posterior wall of the larynx, though not inside the lumen. Such good results were, however, very uncommon.

Dr. FITZGERALD POWELL thought these cases very interesting and

strongly bore out the view he held that the improvement or cure of tuberculosis of the larynx depended in great measure on the state of the lungs, whether the disease was active or not in the lungs. He had had cases in which the disease was quiescent in the lungs and what appeared to be a complete cure took place in the larynx, but in a year or two afterwards the disease in the lungs became active again, when inspection of the larynx took place. These cases appeared to him to raise the question as to whether tubercular laryngitis should be treated in the London hospitals or sent to open-air sanatoria.

Dr. H. SMURTHWAITE said that within the last two months he had had patients with marked tuberculous disease of the larynx under sanatorium treatment. One man, who had put on two stones in weight, had a swelling of both arytenoid joints and ulceration of the right cord, and had practically lost his voice. After six weeks in a sanatorium the swelling of both joints had gone down remarkably, but there was still slight ulceration of the cord. A case sent for sanatorium treatment a fortnight ago had greatly improved in general condition; there had not been time to see whether the larynx would improve with the lungs. Such cases as shown by Dr. Thomson enabled a much better prognosis to be given to the patients and their friends. One was generally asked whether there was a complete cure for such cases, and while it could not be said that there was, it could be stated that there were cases which did get better.

Dr. DUNDAS GRANT asked whether the ulceration involved the framework and margins of the larynx—*i. e.* the edge of the epiglottis and posterior part of the ary-epiglottic folds, so as to produce odynphagia. That symptom seemed to justify some very active measures, to enable the patient to take food. Would Dr. Thomson consider it wise to supplement the open-air treatment by local treatment of the larynx?

Mr. BABER inquired whether antiseptic sprays, such as menthol, were employed in these cases. One often saw such cases run a very chronic course under this treatment.

Dr. WATSON WILLIAMS asked how long the cases had been under observation. He (Dr. Williams) made a sketch of the condition, but he did not remember how long ago. Still, he knew it was sufficiently long ago for any impending lesion to have declared itself long since. The cases showed the excellent results from open-air treatment, combined with complete rest of the larynx. In some cases so treated, however, a localised lesion remained, very chronic, and matters could be much expedited by local removal of that focus.

Dr. DE HAVILLAND HALL said that two years ago, in the spring, a gentleman, aged seventy-two years, consulted him on account of loss of voice, cough, and loss of flesh. Before examining his larynx he (Dr. Hall) thought he had malignant disease, it having lasted some weeks; but he found ulceration of both cords, and chest examination showed a suspicion of mischief at the right apex, slight impairment of resonance, and a little crackling on coughing. Tuberle bacilli were found in fair numbers in the sputum. He sent the patient to live in the open air at Bournemouth, and gave him an antiseptic spray, consisting of menthol, eucalyptol, and oil of cinnamon, to be used every four hours, and he was enjoined not to speak at all, but to write his requirements. In addition he had 5 grs. of carbonate of guaiacol three times a day. In three months the patient returned, having put on a stone and a half in weight, the ulceration was completely healed, and when nine months later he had to see the patient over another matter, the signs of lung disease had disappeared, and the larynx was

apparently quite well. It was unusual for a man of that age, previously well, to have tubercle and recover so well.

Dr. ATWOOD THORNE said that five years ago he saw a man with marked tubercular trouble in his larynx. He at once sent him to Ventnor. He had been a heavy drinker. After four months' stay he was quite well. There was no local treatment whatever.

Dr. STCLAIR THOMSON, in reply, said the woman who had tracheotomy done had much dysphagia at one time, and had the typical oedematous arytenoids. But there was never any ulceration on the pharyngeal surface; it was limited to the glottic region. Dr. Watson Williams made the drawing of the man three years ago. The cases under discussion had not had sanatorium treatment; they had not left their homes, one of which was at Plumstead and the other at West Ham. They were not good disciples at first; they were smothered with clothes, and had never slept with the windows open. He hoped on a future occasion to bring some private patients on whom he had carried out local treatment. In reply to Mr. Baker, he would say that while sprays were useful in keeping the larynx clean in hospital patients, they were not necessary in the open-air treatment, as the larynx then got clean of itself.

BILATERAL FRONTAL SINUS OPERATION (KILLIAN).

Shown by Dr. STCLAIR THOMSON. This patient, a man aged twenty-three, was operated on in June last. The frontal sinuses were very large. Although there is some depression over the left frontal sinus, it is seen that the aesthetic result is excellent. This result is due to the careful preservation of the Killian bridge and of the septum between the two sinuses, as well as to the carefully planned and adjusted incisions. The permanency of the opening into the left sphenoidal sinus is well seen. The patient still has some pus in the right nostril, doubtless from one of the ethmoidal cells.

Mr. STUART-Low said he had examined the case and was pleased with the result. But there was a good deal of depression over the site of the bone removed on the left side, and he suggested that Dr. Thomson should do as Killian had done in such cases, inject paraffin to remove the deformity. Killian's usual incision was a little different from that done by Dr. Thomson, being carried almost straight down to the bony edge of the nostrils. Killian's incision enabled better access to be obtained to the ascending process of the maxilla, which, of course, had to be removed.

Dr. STCLAIR THOMSON, in reply, said he would put a little paraffin in if desired. He copied the incision which he carefully learned from Killian three or four years ago. Killian pointed out that in all operations on the face the incision should be a curved one, as that was less noticeable, following as it did the natural curves of the face, than a straight cut.

STENOSIS OF THE LARYNX.

Shown by Dr. H. J. DAVIS. A woman, aged forty-four, with dyspnœa and stridor, according to her statement of "twelve

months' " duration. The glottis was stenosed and ulcerated. She had had three miscarriages and pleurisy four times, and had physical signs of thickened pleura on left side. The throat was painless; no glands were present in the neck, and the patient was emaciating.

Dr. DAVIS said she had no physical signs of active disease, but she had signs of old pleurisy. She did not originally seek relief for herself, but when attending at the hospital in charge of a child her attention was called to her stridor; this was three months ago. The case was shown for diagnosis. She was now much worse, and he thought it was malignant disease, despite the fact that she had physical signs in the lungs. There was no sputum, but she was emaciating rapidly.

Dr. DUNDAS GRANT considered the evidence to be in favour of tuberculosis.

**INOPERABLE CANCER OF FAUCES TREATED WITH A BACTERIAL VACCINE
OF *Micrococcus neoformans*. (Shown on June 1, 1906.)**

Shown by Dr. SCANES SPICER. The patient, a man aged seventy-five, was previously shown on June 1 with inoperable cancer of the fauces and the adjacent structures. The patient had undergone a further twenty weeks' treatment with a bacterial vaccine of *Micrococcus neoformans*. He had gained 2 lb. in weight. The malignant growth had receded in one part but was more prominent in another.

The PRESIDENT said he thought the case looked a little better now than on the last occasion he saw it.

Dr. B. H. SPILSBURY gave the following description of the microscopical appearances of the growth:

Histological examination of a piece of the growth, which was removed on April 6, 1906, showed a spheroidal-celled carcinoma. The masses of cancer-cells had very uniform appearances in every part of the sections; there were no degenerative changes in the cells, but very numerous mitotic figures were present indicating a rapid growth.

The stroma of the growth was small in amount and was closely packed with connective-tissue cells, the majority of which were mononuclear cells and corresponded in morphological characters with the plasma-cells of Unna; there were small numbers also of polymorphonuclear leucocytes and a few coarse eosinophilous cells.

A second piece of the growth was examined histologically six months later on October 10, 1906.

The masses of carcinoma cells showed no alteration in character

throughout the greater part of the mass, but in a few spaces the cells had shrunken in size, and their nuclei were smaller and more compact and showed fewer mitotic figures, suggesting some slowing in the rate of growth. There were no degenerative changes in the cells.

The chief changes were in the stroma, which in places was entirely free from infiltration with connective-tissue cells and in other places showed small collections of cells which were almost all of the type of polymorphonuclear leucocytes.

In short, there appeared to be some attempt at the production of an adult connective tissue, an attempt of which there was little or no evidence in the section examined six months previously.

Mr. STUART-Low suggested that as practical surgeons they might make use of this treatment preparatory to operation to get rid of the suppurative and inflammatory conditions of the malignant tumours, these conditions being known to be very inimical to successful results.

Dr. SCANES SPICER, in reply, said the changes in size and the different parts of the growth varied very much. He feared that the growth was rather larger again since he saw the case a fortnight ago. Injections had been regularly kept up. There was sufficient proof of the influence of the injection in the fact that though it was eighteen months since the man came under observation he was still comparatively well, and had actually gained weight. He had had a second case, which was considerably improved in the matter of cleanliness and in the reduction of the swelling, as well as in the increased mobility of the tongue and jaw. He certainly thought the patient ought to be given a chance of the treatment if he had inoperable carcinoma of the pharyngo-oesophagus ; he knew of nothing more promising.

FIXATION OF THE RIGHT VOCAL CORD WITH DYSPHAGIA FOR LIQUIDS.

Shown by Mr. STUART-Low. The patient, a woman aged fifty-six, sought relief on October 20 last, on account of difficulty in swallowing liquids. She said that she had suffered from this for three months and that it was increasing. There was a history of recurrent attacks of rheumatism. One year ago she had an attack of influenza and since then she had been very liable to catch cold. There is nothing of the nature of specific disease in her past history. She is the mother of thirteen children, most of whom are living. There is no difficulty in passing the largest oesophageal bougie nor in swallowing solids. When an attempt to drink is made the fluid apparently passes through the fauces and into the upper part of the oesophagus, when coughing begins. It seems as if some of the fluid gains entrance to the

larynx and thus sets up reflex coughing. She expresses herself as certain that cold liquids pass with less coughing than warm. The right vocal cord is seen to be completely fixed in the cadaveric position. The arytenoid cartilage during voice-production moves a little forwards and inwards, but much less than normally. The tension of the fixed cord appears to be normal.

A small mass of rather firm, enlarged glands, somewhat painful on pressure, can be felt in the superior deep cervical group on the right side. The chest shows no evidence of disease and the nervous system seems normal, and a skiagram shows nothing unusual. She has lost weight to the extent of one stone in nine months, during the last month has felt very much less energetic than usual. The cause of the paralysis of the right vocal cord and of the peculiar symptom of coughing on trying to swallow liquids is difficult to explain; one explanation might be that there existed a malignant growth in the oesophagus implicating the right recurrent nerve, this nerve being situated more posteriorly than the left. This would not only account for the paralysis of the cord, but for the weakening of the sphincter muscle keeping guard over the entrance to the larynx. If some fluid entered the larynx on attempting to swallow liquids, the superior laryngeal being intact, coughing would ensue.

Dr. DE HAVILLAND HALL said that last year he had a lady, aged twenty-three, who complained of slight hoarseness and difficulty in swallowing liquids, though she could swallow solid food perfectly. He found paresis of the right vocal cord, and he heard that she had been exposed to cold. Probably she got a slight neuritis, and he put her upon iodide of potassium, and went in for electrical treatment. She was going out to India. She improved rapidly, and got quite well. He believed the difficulty in the present case arose from imperfect closure of the larynx. He could not say what was the cause of the fixation of the cord.

Dr. FITZGERALD POWELL said he understood there was a history of influenza in this case. The vocal cord was paralysed, but there was some movement in the arytenoid. Some time ago he had shown a similar case to the Society, and the general opinion of the members was that the paralysis of the cord was due to the toxin of influenza. The patient had had iodide of potassium and strychnine, but he got better suddenly and not apparently as the result of any treatment.

Mr. STUART-Low, in reply, said his patient, like Dr. de Havilland Hall's, could swallow cold fluids better than warm, probably because of the stimulating effect on the sphincter of the larynx. He had not yet treated her, but proposed to try potassium iodide. The influenza occurred only three months ago, and this would be a very long time for the toxin to be still active, supposing influenza to be the original cause of the laryngeal paralysis.

A CASE OF EPITHELIOMA OF THE LARYNX.

Shown by Dr. WATSON WILLIAMS. The growth involved the epiglottis, the right aryepiglottic fold, and arytenoid region, extending to the right glosso-epiglottic fold and the contiguous portion of the lateral wall of the pharynx. There was an enlarged gland, corresponding to the tip of the great cornu of the hyoid bone on that side. The patient had complained of pain extending up to the right ear since June, and a month later hoarseness was noticed, and he had been losing flesh.

Microscopical evidence of a fragment left no doubt as to the histological character of the growth. He showed the case with a view to receiving suggestions as to the possibility of successful removal by operation.

MALIGNANT DISEASE OF THE RIGHT SIDE OF THE LARYNX IN A SYPHILITIC MAN AGED SIXTY.

Shown by Dr. STCLAIR THOMSON. This patient has been losing his voice for about a month. Lues was contracted twenty-five years ago. The right vocal cord is concealed by a diffuse ulcerating infiltration, which spreads all over the right ventricular band, the aryepiglottic fold, and upwards on the epiglottis. The sides of the ulcer are deeply cut. There is no fungation, sloughing, or odour; some dysphagia. The glands below the right jaw are enlarged but not fixed. The right vocal cord is concealed, so that we cannot tell if its action is impaired. He has taken 15 grs. of iodide with mercury for nearly three weeks, and for ten days he has had inunctions of mercury. At first the surface cleaned up in a remarkable way, but latterly there has been no progress. Opinion was invited as to whether the growth was undoubtedly malignant, whether anti-syphilitic treatment should be given a fresh trial, and whether the case was suitable for hemi-laryngectomy.

A CASE OF GLOSSO-PIGLOTTIDEAN LYMPHO-SARCOMA.

Shown by Dr. DUNDAS GRANT. The patient was a man aged thirty-one, who complained of dryness and soreness of the throat of three months' duration, and of a swelling of which he had been conscious for one month. On depressing the tongue, an irregular, smooth-surfaced, fleshy growth came into view, and, by means of the laryngoscopic mirror, it was seen to involve the posterior part of the tongue so as to completely conceal the larynx. On raising

the posterior part of it a small portion of the right edge of the epiglottis was exposed ; the voice was perfectly clear, and respiration so free that it was obvious that the deeper part of the larynx was not affected. There were no enlarged glands, and the microscopical examination of a small portion of the growth proved that it was a typical lympho-sarcoma. Opinions were invited as to the advisability and methods of removal, the exhibitor being inclined to think that trans-hyoid pharyngotomy would suffice.

[*Supplementary note.*—The operation, as described and recommended by Mr. Butlin, has since been carried out, and the patient is making satisfactory progress.]

Mr. BUTLIN thought that, for the purpose of discussion, it would be convenient to group together with Dr. Watson Williams' case those shown by Dr. StClair Thomson and Dr. Dundas Grant. The disease in all three cases was of the base of the tongue and upper part of the larynx. In two of them the glands were involved, but probably within the reach of an extensive operation. He was of opinion that an operation should be performed in all cases. It should comprise removal of the contents of the anterior triangle on the affected side, with ligature and removal of the external carotid artery and all its branches. It would be well at the same time to remove the external carotid artery and its branches on the other side of the neck. A few days later the removal of the primary disease could be performed with scarcely any haemorrhage and as freely as might be desired by opening up the wound for the removal of the contents of the triangle. He had performed this operation on several occasions, and was quite satisfied that it afforded the best view of the affected parts and of the whole field of operation. Unless this were done, it was useless to attempt these operations.

A CASE OF ULCERATION (? MALIGNANT DISEASE) OF THE BASE OF THE TONGUE.

Shown by Dr. W. H. KELSON. The patient, a man aged forty-eight, first complained of swelling in his throat, and alteration in his voice in April ; he was admitted into hospital August 25, when there was found to be a large, red, rounded swelling at the base of the tongue, which was bound down on the right side and could not be protruded ; on the right side of the swelling was an ulcer. The administration of iodide of potassium gave no result, and a month after admission profuse haemorrhage took place from the ulcer and the swelling subsided ; the submaxillary lymphatic glands were enlarged on both sides. Since the haemorrhage the patient has gained weight and improved in health. No tubercle bacilli or lung signs could be detected nor microscopical appearances of actinomycosis. Opinions were requested as to the nature of the case.

A CASE OF PAPILLOMATA OF THE LARYNX.

Shown by Dr. H. J. DAVIS. A girl, aged eighteen, with papillomata in the larynx. Three years ago she had had the same trouble, and all the growths were removed with snare and forceps. "She kept well for three years" but now had recurrence. The growths were very easy to see, situated above and below cords, and he hoped that he could remove them again in the same way.

Dr. WATSON WILLIAMS showed a tongue clip, which he had devised and had found exceedingly useful in operations about the mouth. It was made by Messrs. Mayer and Meltzer.

Dr. WATSON WILLIAMS showed drawings illustrating the method which he had been in the habit of adopting in the operation for submucous excision of the septum, the essential point of which was a small preliminary incision made on the concave side, by means of which a narrow elevator could be inserted, so as to remove the muco-perichondrium from that portion of the quadrilateral cartilage which later corresponded to the incision through the cartilage, after the ordinary incision in the mucous membrane had been made and the muco-perichondrium lifted from the convex side, as was usual with the ordinary button-hole incision. The advantage, he pointed out, was that when the cartilage was incised there was no risk of the mucous membrane on the concave side being divided, because it had already been lifted. The method he adopted and advocated whenever suitable.





PROCEEDINGS OF THE LARYNGOLOGICAL SOCIETY OF LONDON.

One Hundred-and-ninth Ordinary Meeting, December 7, 1906.

J. B. BALL, M.D., *President, in the Chair.*

HENRY J. DAVIS, M.B. }
W. JOBSON HORNE, M.D. } Hon. Secretaries.

Present—32 members and 2 visitors.

The minutes of the previous meeting were read and confirmed.

The following gentlemen were elected as ordinary members:

GEORGE W. BADGEROW, M.B. Toronto.
CYRIL A. B. HORSFORD, F.R.C.S.

The following communications were made:

CYST IN THE FLOOR OF THE RIGHT NASAL PASSAGE.

Shown by the President, Dr. J. B. BALL. The patient is a woman aged fifty-two. There is a swelling in the anterior part of the floor of the right nasal passage, which is obviously a cyst. She thinks it has existed for about nine or ten years. Although it gives rise to slight deformity in the anterior naris, it causes no inconvenience, and she does not wish for any operative interference.

Dr. DAVIS said he remembered showing, five years ago, a woman who had a cyst on the same side. Each time it was punctured it refilled and expanded part of the inferior turbinate bone. The mucous glands had very long canals in those parts, and he thought it was a retention-cyst of one of those glands. He thought that it occurred, as a rule, in women.

Mr. H. B. ROBINSON said he could contradict the statement that the condition occurred only in women. He had removed one from the same position in a man.

Dr. HERBERT TILLEY confirmed Mr. Robinson's statement that cysts on the floor of the nose sometimes occurred in men. He had treated such in a man where one of the incisor teeth was at fault. When that tooth had been removed the cyst ceased to refill.

Dr. LAMBERT LACK suggested that all such cysts were dental in origin.

Dr. STCLAIR THOMSON said he had one peridental cyst which was

treated in the country first of all, where it was thought to lead into the antrum, but it washed through into the floor of the nose. He had had some previously, which he had treated from the gum, but was dissatisfied with them. A present case, which was doing better, he was treating by dissecting it from the gum and dealing with it from inside the nose at the same time. He agreed with Dr. Lack that they were nearly all peri-dental cysts.

CASE OF PARALYSIS OF THE RIGHT HALF OF THE TONGUE, THE RIGHT HALF OF THE PALATE, AND OF THE RIGHT HALF OF THE LARYNX (ABDUCTOR PARALYSIS), IN A CASE OF (?) SYPHILITIC PACHY-MENINGITIS.

Shown by Sir FELIX SEMON. The patient, a man aged forty-two, was admitted to the National Hospital for the Paralysed and Epileptic under the care of Dr. Ormerod on October 31, 1906. He has had gonorrhœa, but there is no definite history of syphilis. Two and a half years ago he rather suddenly lost power in his right leg, and has never quite recovered this. One year ago he had malaise, vomiting, and sudden loss of power in the left leg. He is able to walk, but both legs are weak and do not seem to have their proper feeling, particularly the left. Five months ago his voice became raucous, and has ever since remained so. He has some difficulty in passing water, and occasionally generalised headache.

His state on admission was as follows : Cerebration is very slow ; smell dull, better left than right ; taste dull on both sides ; hearing very poor, left better than right Vision : Right, old iridectomy from injury, some opacity of media. Left, $\frac{6}{6}$. No restriction of fields, rough test, left pupil small, reacts to stimuli through small range, slight double ptosis, no defect of ocular movements ; diminution of sensation over right fifth, weakness of right motor fifth ; weakness of right facial ; paresis of right half of palate ; right laryngeal abductor paralysis ; voice high-pitched, somewhat hoarse ; tongue protruded distinctly to the left side fuller than right ; some difficulty in swallowing solids ; slight weakness of right arm : spasticity of both legs, diminution of sensation over the whole left half of the body ; all deep reflexes exaggerated, double extensor response not constant on left side. (For these notes I am indebted to Dr. Wilson, our Senior Resident Medical Officer.)

From the above description it is obvious that there is a process of meningeal thickening at the base of the brain, implicating a number of cerebral nerves as they leave the cavity of the skull in

the right middle and posterior fossæ. Amongst them there is the triad of symptoms—paralysis of one and the same half of the tongue, palate, and larynx described many years ago by Hughlings Jackson and Morell Mackenzie, Bernhardt, Stephen Mackenzie, Barlow, and other authors. Cases of this description are sufficiently rare to be individually recorded.

The patient has not improved under mercurial treatment, electricity, and massage during his stay in the hospital. During the past fortnight his articulation has become rapidly worse.

CASE OF NÆVUS OF THE PHARYNX.

Shown by Dr. DUNDAS GRANT. The patient, a man aged twenty, was first seen by the exhibitor on November 9, 1906, complaining of pain and fulness in the left side of the throat. There is an extensive nævoid growth involving the left half of the palate, fauces, and lateral aspect of the pharynx. Externally, behind and below the angle of the jaw, there is a fulness giving the "wormy" sensation of a vascular swelling. The condition is reported to have been present since birth but to have been getting larger of late, and the question arises as to the possibility of its eradication by means of electrolysis, galvano-cautery, or free excision preceded by ligature of the branches of the external carotid artery, if the latter proceeding is not rendered impossible by the outward extension of the nævoid growth.

Dr. F. W. BENNETT said that as the condition was only found by accident, and as it gave rise to no symptoms, he would leave it alone.

The PRESIDENT agreed with Dr. Bennett, and counselled leaving it alone.

Dr. FITZGERALD POWELL said he had two similar cases, one of them a nævus of the tongue and palate, which he showed at the Society, and it was generally thought they should be left alone. They had remained in the same condition, and there seemed to be no ill effects. He saw another case in a French boy, for whom he recommended some treatment; but his friends took him away in a panic, and went to Paris, where his tongue was slit up, one flap being turned above and the other below, and the nævus dissected out. The boy nearly bled to death, but his nævus was now as large as ever. He thought these cases were better left alone unless bleeding occurred.

Dr. GRANT said, in reply, that the opinions expressed coincided very much with his own, but he felt it his duty to ascertain whether more heroic measures would be suggested. The patient had had no haemorrhages, but if they were to set in, the complexion of the case might be altered. He thought the local application of the galvano-cautery would then be most likely to do good.

A CASE OF OZÆNA FOR DIAGNOSIS.

Shown by Dr. H. J. DAVIS. A lady, aged forty-three, had had ozæna for two months. There were present hypertrophic rhinitis and post-nasal discharge : transillumination gave a negative result.

The patient was the wife of a professional man, who had noticed the odour suddenly two months ago. She was now conscious of the odour herself, and said that a discharge trickled down the back of the throat. Pus was visible with a post-nasal mirror in the vault of the naso-pharynx, but the exhibitor was not sure that ulceration was not present : he would be glad of the opinion of members on the case as to diagnosis and advisability of operation.

Dr. HERBERT TILLEY said that in the post-nasal space there appeared to be the remains of an old adenoid, in the middle line, and on that mass were five or six small suppurating points, so that he took it to be a chronic abscess located in the post-nasal growth. The smell of the condition would be in keeping with that diagnosis. He had removed a suppurating adenoid from a patient aged thirty-five, and the wall of the abscess cavity was black. The patient had been seeking advice because of a very foul smell in the nose. This was always preceded by a headache, and the patient said that when something "burst in the middle of her head, and some stuff came away" the symptoms were relieved. When he broke into it on digital examination of the naso-pharynx the pus which escaped was of the foulest odour he had ever experienced. When he removed the adenoid he mopped out the post-nasal space with chloride of zinc, thirty grains to the ounce, but in spite of that and frequent douching she suffered from general septic intoxication, and came out in a rash resembling scarlet fever a few hours after the operation. Three days afterwards she had acute suppuration in the right antrum and exhibited a septic temperature, which lasted a week, and then the whole trouble passed off. He thought removal should be carried out in this case and the condition of the nasal passages investigated under an anæsthetic. Possibly at the same time the anterior end of the inferior turbinal on the right side could be removed, as it was very swollen. Information could be gleaned at the time of operation by looking at the deeper parts of the nose with a Killian's speculum. There might be a secretion of pus from the sphenoidal sinus, but from the patient's answers to questions he did not think this was the case ; it was a question that could not be excluded without proper and detailed examination.

Dr. DAVIS, in reply, said he thought the patient had more discharge running down the back of the throat than she would have from mere suppuration of adenoids. He believed she had sphenoidal sinus trouble, but he agreed that she had a pad of adenoids. When he first saw her it looked like a case of Tornwaldt's disease ; but that was very rare, and he had only seen it twice in his life, though but for the amount of discharge he would have regarded it as a case of that disease. The friends were anxious to know what was best to be done, and he did not want to suggest an operation which would not cure her. He thought it would be best to give an anæsthetic and remove the growth first. He gave her a spray of hydrogen peroxide to both nostrils, which effervesced freely and removed the odour. He was grateful for the advice which had been offered.

A CASE OF LARYNGEAL NEOPLASM FOR DIAGNOSIS.

Shown by Dr. H. J. DAVIS. The patient, a man aged forty-four, was taken suddenly ill six weeks previously with stridor, retraction of ribs, slight dysphagia. The aperture of the larynx was almost occluded by infiltrated arytenoids. There were no physical signs in the chest.

The exhibitor said he had never seen a similar case before and he thought that it might be anything—syphilis, tubercular or malignant disease. The severity of the symptoms was unusual; stridor was now less marked; the patient was under treatment with inhalations and a mixture of 15 gr. of iodide of potassium and 1 dram. of Easton's syrup three times a day. He would be glad of the opinion of the Society on the case.

Dr. GRANT thought the œdema in the arytenoids was secondary to some tertiary syphilitic condition in the posterior part of the larynx.

Dr. JOBSON HORNE said he was only able to make a hurried examination of the case, but it was one which required careful investigation. The first thing to exclude was malignant disease and then tubercle. The question arose whether the stridor and shortness of breath were entirely attributable to the laryngeal condition, or whether there was a mass of glands in the thorax, causing pressure and dyspnœa. An examination of the neck and thorax with the X rays, Dr. Horne thought, would be helpful in arriving at an exact diagnosis.

Mr. CHICHELE NOURSE said that besides the infiltration of the arytenoids, the ventricular bands were very much swollen. He agreed with the opinion expressed by Dr. Grant that it was probably a tertiary specific affection, and he thought there was some perichondritis.

Dr. STCLAIR THOMSON said that if tubercle had been excluded he agreed with Dr. Grant that it was most likely tertiary syphilitic. He had an exactly similar case in which the infiltration looked very œdematosus. He pressed the man to enter the hospital and have tracheotomy done, but he refused. The stridor got worse, and one day he was brought into the hospital in a great hurry. The house-surgeon did tracheotomy, but the man was dead before it was completed. He (Dr. Thomson) had the specimen. There was a pedunculated thickening which, to the touch, was very solid and fibrous. But in the mirror it, like the present case, had looked semi-translucent.

Sir FELIX SEMON did not think anyone could say, from mere laryngoscopic examination, what the nature of the condition was. Certainly there was perichondritis, with œdematosus infiltration of the mucous membrane, but whether it was tuberculous, malignant, or syphilitic was mere guesswork. Why should it be syphilitic? Was it a syphilitic ulcer? Or were there other syphilitic phenomena? And tuberculosis had not at all been "excluded." Again, the man was forty-four, therefore he might have malignant disease of the œsophageal aspect of the larynx, concealed at present by the œdema over it. He would give iodide, and at the same time examine the expectoration for tubercle.

Mr. E. B. WAGGETT thought that in all cases where there was doubt as

to the condition of the posterior aspect of the cricoid that part should be examined by inspection. It could be easily done by a method devised by Dr. von Eicken, and in vogue in Professor Killian's clinique, namely hooking forward the larynx with a very strong curved probe, the tip of which, covered with wool, was applied below the anterior commissure after a good cocaineising of the part. In that way information could be gained in this case as to the suspected presence of malignant ulceration of the posterior aspect of the cricoid.

Dr. DAVIS, in reply, agreed with Sir Felix Semon. A remark was made about excluding tuberculosis, but how was that to be done? There was no sputum to be examined. One could only judge by the clinical results. The case was a very rapid one. The man was taken suddenly ill, and when seen in the out-patient department he was thought to be suffocating. He was given some Friar's balsam to inhale and an injection of morphia, under which he got better. He had been treated with iodide of potassium. He had never yet seen the ventricular bands, and if they were visible now the man was better. The only case at all resembling it which he had seen was where the swelling was translucent. That was secondary syphilis. In the present case the parts were very red, and he had never seen a man get bad so quickly or improve so rapidly. If it had been tuberculous he thought the man would have got worse under the iodide of potassium; that was his experience.

CASE OF MULTI-SINUSITIS.

Shown by Dr. STCLAIR THOMSON. Every cavity had been dealt with surgically except the right sphenoid. The opening into the left sphenoid was well seen, and also the complete clearance of the left fronto-ethmoidal cells. The Killian operation had been performed on each frontal sinus with removal of the entire roof of the orbit. In consequence of local foci of suppuration repeated operations on the fronto-ethmoidal cells were required, leaving scars on the forehead. Owing to local massage and the preservation of the Killian bridge hardly any disfigurement had resulted.

Dr. SCANES SPICER congratulated Dr. StClair Thomson on the excellent result of the left side. It was seldom one saw such a fine opening into the sphenoidal sinus and such complete quiescence after extensive interference. On the right side the tissues in connection with the adhesion looked to him congested, and he did not think the present satisfaction as to relief would be permanent, and that something more would have to be done for the patient before very long—*e. g.* division of the adhesion and submucous resection of septum. He did not think as things were there was sufficiently free drainage of the ethmoidal cavities, and he could distinctly see and feel small polypoid proliferations in the depths of the right nostril.

A LARYNGEAL CYST IN THE ARYTENO-EPIGLOTTIDEAN FOLD.

Shown by Dr. G. C. CATHCART. The tumour was about the size of a filbert nut, and extended from the left arytenoid along the

ary-epiglottic fold, and projecting over the ventricular band on that side, it presented the appearances of a tense cyst. The case was exhibited to ascertain opinions as to treatment.

Sir FELIX SEMON said he had seen several cases of cyst of the larynx, and his universal experience had been that if they were simply tapped they filled again quickly. Even where a large piece had been removed from the cyst wall he knew of a case in which the cyst had refilled again and again. If it were to cause trouble in breathing, singing, or swallowing in the present case he recommended that it should be snared off *in toto*.

Dr. JOBSON HORNE said that a few years ago he showed a somewhat similar case, which he treated with a snare. He had treated similarly a case previous to that. He recommended the use of an electric snare. The snare should be applied cold, and when drawn home the current connected at the last moment. In that way a clean removal would be effected, and with a minimum destruction of the adjacent parts.

The PRESIDENT asked how the cyst was discovered, as the lady had no symptoms.

Dr. CATHCART replied that the cyst was discovered quite accidentally during the routine examination, the patient having come complaining that her nose was stuffed up owing to a cold. She wanted it washed out, as she was going to sing next day.

A CASE OF ULCERATION IN THE INTERARYTENOID SPACE.

Shown by Dr. CATHCART for diagnosis. The patient, a man aged fifty-two, had been unable to swallow solids for the previous six weeks.

Dr. DAVIS said he did not think the trouble in the larynx was sufficient to account for all the symptoms ; he was of opinion that it proceeded from the oesophagus.

Mr. ROBINSON asked whether the patient's sputum had been tested for tubercle bacilli.

Dr. FURNESS POTTER asked whether Dr. Cathcart had passed an oesophageal bougie. He had carefully examined this case, but could see no ulceration. There was certainly no visible loss of tissue in the interarytænoid space.

Dr. CATHCART replied that the sputum had been examined for tubercle bacilli, but with a negative result.

A CASE OF COMPLETE ABDUCTOR PARALYSIS.

Shown by Dr. G. C. CATHCART. The patient, a woman aged thirty-six, had had tracheotomy performed. The left cord was now fixed in the cadaveric position ; the right cord was slightly movable.

The PRESIDENT asked whether Dr. Cathcart had come to any conclusion as to the cause of the trouble and as to the nature of it.

Dr. GRANT asked whether the patient had been having specific treatment since the date two months ago which was mentioned.

Dr. CATHCART replied that the patient came in July with œdema of larynx, and was put upon antisyphilitic treatment. She remained on that for about a week, but did not return until two months ago. She was then so bad that intubation had to be done at once. Since he saw her a fortnight ago both cords were much more movable than the description mentioned. She had had no specific treatment since she left the hospital.

CASE OF PERSISTENT JACOBSON'S ORGAN.

Shown by Dr. LAMBERT LACK. The patient, a man aged about thirty, presents a small sinus on the left side of the septum near the floor of the nose about half an inch behind the vestibule. The opening of this sinus is about the size of a pin's head, and it admits a fine probe for three eighths of an inch. This sinus is obviously congenital and almost certainly represents the persistent remains of Jacobson's organ. Dr. Arthur Keith, who kindly saw the case with me, concurred in this opinion, and found a reference to a record of another similar case.¹

Dr. GRANT said that in a French paper on the subject a number of years ago it was pointed out that the cystic part landed considerably higher up on the septum of the nose and that the cartilage remained low down. One had to look considerably higher up for the duct and cyst.

A CASE OF EPITHELIOMA OF THE TONGUE AND LARYNX.

Shown by Mr. E. ROUGHTON.

Dr. SCANES SPICER said if surgical measures were adopted in this case he considered it was a case for complete laryngectomy and that some portion of the pharynx would also have to be removed, and in the light of Gluck's results he thought this was a favourable case if the trachea were completely divided and brought out into the neck and even to the skin, so as to shut off completely the lungs from the pharyngeal and buccal wound. He had had one such extensive case in conjunction with two of his general surgeon *confrères*, and had attempted to bring out the trachea, remove the diseased larynx, portions of pharynx, and œsophagus, and also the glands at the same operation, which lasted nearly four hours. The patient stood the operation, but succumbed from cardiac thrombosis twelve hours after. In discussing the case with Professor Glück afterwards, the latter advised in a similar case to remove the glands first, at an independent operation before the extirpation.

¹ Mangakis (Athens), "Ein Fall von Jacobson's-chen Organ beim Erwachsener," *Anat. Anzeiger*, 1902, Bd. xxii, S. 106.

A CASE OF ACHONDROPLASIA IN A CHILD AGED THREE YEARS.

Shown by Dr. SCANES SPICER to illustrate the congenital pug-nose, with all the axial and postural and many of the appendicular features of achondroplasia.

The case had been sent to him from the country on account of mouth-breathing and panting of an exaggerated type, with the tongue in a fixed extruded position on any exertion, extreme depression of root of nose, and alternating internal strabismus—all from birth. She could not talk, stand, or walk, though her mental state seemed not to differ much from the usual child of the same age. The parents had been told that the symptoms were due to adenoids and enlarged tonsils, and wanted to know if an operation would be remedial. On watching the child was seen occasionally when she pulled herself up to breathe perfectly through the nose for a short time, though she relapsed as a rule into mouth-breathing, which gave her a vacant imbecile look. On sitting her in a chair she assumed the position of kyphosis, and on placing her at a table she sprawled over it in a weary way, and rested in a position suggesting scoliosis. On trying to get her to stand she would often collapse on the buttocks and fall over so that the face touched the toes; or if she succeeded in standing her posture was that of lordosis, with protuberant abdomen, upper straight spine, head forwards, mouth open, tongue out, apparently short legs, and her profile and proportions identical with that of the recent photos of achondroplasia published in the *Transactions* of the Royal Medical and Chirurgical Society, vol. lxxxix, p. 409, 1905, and *Lancet*, June 9, 1906, p. 1598. The child was of an exceedingly restless and irritable temperament, and in order to secure skiagrams of the head and chest it was necessary to administer a general anaesthetic. Under anaesthesia it was found that all the deformity of the spine was postural and not organic, and that the height was 35 inches as against 28½ when measured standing against the door. Further, the nasal breathing became perfect, and was then associated with proper costal respiration. On recovering from the anaesthetic, the mouth opened and the breathing became exclusively abdominal again. It was therefore clear that the breathing obstruction was not in the main due to structural changes in the nasal passages or to adenoids; nor did the tonsils suffice to explain it, though they were considerably enlarged. I would provisionally tender the suggestion that the obstruction is due to an excessive flexure of the head on the cervical spine, so that

the body of the axis crowds into the stunted achondroplastic naso-pharynx.

On further examination of the case it was found to agree with previously published accounts of the disease in the following points: (1) congenital origin; (2) depression of the bridge of the nose at the root; (3) distinct shortening of the lower limbs with normal development of the trunk; (4) wheel-spoke appearance of hands (*main en trident*); (5) excess of adipose tissue in the folds of the skin; (6 and 7) protuberant abdomen and apparent lordosis when standing; (8) smooth, pliable skin with fine glossy hair; (9) palate of the high-vaulted character with irregular position and delayed eruption of the milk-teeth; (10) approximately normal mental condition.

It appears to differ from some previously recorded cases in: (1) size of the cranium not disproportionately enlarged, though dome is abnormally high; (2) no prognathus; (3) no beaded ribs or enlarged bone ends.

I must leave doubtful at present the position of centre of body, exact measurements and proportions, and results disclosed by skiagrams. The age and temperament of the child render it difficult to procure rapidly a complete examination and report, and a distant residence in the country makes it advisable that I should seize the opportunity of the child's being present in London on the day of the meeting of our Society to bring the case forward. The interesting problems arising around nasal obstruction in this case, that due to adenoids, extreme mouth-breathing, the typical achondroplastic features and associations here will at once occur to every member of the Society, and time will not permit me to discuss fully now even those which I have thought out.

Dr. SCANES SPICER said that two brothers and two sisters had shown similar symptoms in infancy but to a less degree. They had largely outgrown them. This rather pointed to the extreme nasal depression being due to an arrested or delayed growth of the bone centres of the sphenoid and occipital bones rather than a premature synostosis of the pre- or basi-sphenoid as was observed by Virchow in other cases of stunted nose. A specific history could be excluded with practical certainty. Many of the family had had post-nasal adenoid hyperplasia. The eldest sister has high vaulted palate, superior protrusion, and lost the upper front incisors at twenty-one. The elder brother (twenty) is now 6 ft. 2 $\frac{1}{2}$ in., hands and feet of acromegalic type, vaulted palate, superior protrusion, has lost upper front incisors. Second sister has had thyroid gland enlarged. Second brother had tonsils and adenoids removed for obstruction and mouth-breathing. Mother and maternal aunt have distinct acromegalic characters of nose, cheek-bones, lower jaw, and lower lip. In short, the morbid states of this family are chiefly those associated with pathological states of the bony cranial basis,

or the immediately overlying pituitary body, or the subjacent Luschka's tonsil. This can hardly fail to be highly suggestive to members of this Society, who in thinking out to the full the factors in any given case of nasal obstruction must often ponder over Luschka's tonsil, Rathke's pouch, achondroplastic sphenoid, persistent crano-pharyngeal canal and morbid states of the pituitary gland, and wonder if their proximity anatomically lends itself to explain such associations as hinted at above.

CASE OF CHRONIC CEDEMA OF THE LARYNX IN A FEMALE BOARD SCHOOL TEACHER, AGED TWENTY-FOUR (FOR DIAGNOSIS).

Shown by Dr. SCANES SPICER. There is a high degree of firm, oedematous, pale swelling occupying the epiglottis and both ary-epiglottic folds. The appearances would be considered pathognomonic of tubercle if any confirmatory signs of tuberculosis could be found, but three examinations of the sputum for tubercle bacilli have been negative. Sir A. E. Wright reports the tuberculo-opsonic index on two occasions as .78 and 1.26, and that the oscillations are not sufficient to justify a diagnosis of tubercular infection. There is a slight difficulty in swallowing, and the voice is somewhat sharp and peculiar in timbre. There are no physical signs or symptoms of phthisis. On the other hand, the patient is a gasping mouth-breather, and has several foul carious teeth. Is septic infection from these the cause of the oedema? The practical question now was, whether this teacher were to be allowed to resume her duties or to be discharged?

Dr. JOBSON HORNE said he knew nothing about the history of the case or the condition of the lungs, but the condition of the larynx was suggestive of tuberculosis.

Dr. LACK said he had seen the case some months ago and had watched the oedema slowly increase. First of all there was symmetrical oedema of the arytenoids, the rest of the larynx being absolutely free. He at first thought it was tubercle, but the patient was in perfect health now and had put on weight, she had no signs of the disease in the chest and no bacilli in her sputum. He thought tubercle could be absolutely excluded. He did not see anything to warrant the view that it was syphilis, and he did not know what it could be.

The PRESIDENT said that, looking at it that day, one would at once have said, as Dr. Horne had, that it was tubercle, but after the history which had been given, it probably was not so.

Dr. JOBSON HORNE, in further remarks, said an X-ray examination of the thorax would be of great help because he understood that the results of an examination with the stethoscope and the staining reagents had been negative.

Mr. C. A. PARKER said he had seen the case when it was at the Throat Hospital, and that some months ago he had asked Dr. Ironside Bruce to kindly X-ray the patient, thinking that possibly there might be a foreign body lodged in the larynx, but nothing abnormal could be

seen. Dr. Ironside Bruce also took a radiograph of the apices of the lungs, but was of opinion that no trace of tubercle could be seen.

The PRESIDENT said he hoped the Society would be informed about the future of the case.

A CASE OF EPITHELIOMA OF THE LARYNX (SHOWN ON NOVEMBER 2ND, 1906).

Shown for Dr. WATSON WILLIAMS by Dr. SCANES SPICER. This case was admitted into St. Mary's Hospital in order that treatment by a bacterial vaccine of *Micrococcus neosformans* might be tried. This has been carried out by Sir A. E. Wright. In all five injections have been given, twenty-five millions at a week's interval four times and forty millions on the last occasion. The injections have not caused any marked negative phase at all, and the opsonic reaction keeps close to the normal line and rather above it. They cause the patient no malaise. He states he swallows well. Occasionally notices the same pain in the ear as before. He looks a better colour than when shown a week ago. A piece removed for examination confirms diagnosis of epithelioma. I have examined his pharynx and larynx twice a week and do not think the mass is larger or has extended; it is certainly cleaner and paler—less congested. Of course the patient has had the advantage of rest and warmth and ordinary hospital diet and was ordered an alkaline spray, and but for this the only treatment has been bacterial vaccine.

Mr. ROBINSON thought the condition of the larynx was now much cleaner, but that there was more growth than before.

Dr. LACK thought the case would be better operated upon than left until it was too late.

In reply, Dr. SCANES SPICER said that at the last meeting Mr. Butlin had expressed the same opinion as Dr. Lack. The patient was given the option whether he would be operated on for excision of the growth or would make a trial of the bacterial vaccine method. He thought Dr. Watson Williams rather favoured the latter, and the patient agreed. He was quite open to fall in with the suggestion of attempting to extirpate it, if the patient and Dr. Watson Williams desired it and if his surgical colleagues supported that course.

**CASE OF SOLID OEDEMA ON THE LOWER PART OF THE FOREHEAD,
SIDES OF THE NOSE, AND THE LOWER EYELIDS.**

Shown by Dr. HERBERT TILLEY. The patient, a man aged forty-three, had suffered from this condition since he served in the South African War. He thinks the condition started in the skin

near the left tear-sac and originated from a small scratch in that situation. The lower central part of the forehead, the sides of the nose, and the eyelids (more especially the lower) are red and swollen as though the patient had recently been stung in these regions. To the touch the parts are tense and resisting but not painful on pressure. He suffers from severe headache, especially when he stoops. The frontal sinuses had been opened at one hospital but were found to be healthy. Opinions as to diagnosis and treatment were asked for.

Mr. ROBINSON said he had seen three or four cases very similar to this rare condition. He had always called them chronic erysipelas or chronic lymphangitis. Those cases had complained about a sore or crack about the inner canthus, and they had attack after attack of acute redness and swelling until, after a time, they had chronic thickening about the eyes and cheeks. He did not know what treatment to suggest, but if he had a case now he thought he would try antistreptococcal serum.

Dr. GRANT said the man thought he had an undue tendency to bleed, so that it might be a case of defective clotting of the blood, such as was seen in people subject to chilblains and urticaria. The remedy now much recommended for those conditions—namely the salts of calcium—might be worth trying. Lactate of lime seemed to be the least nasty, and doses up to 10 or even 15 gr. three times a day might be given.

Mr. F. J. STEWARD supported the remarks of Mr. Robinson. He had had under his care for some time a somewhat similar case—a young woman whose trouble began with a definite severe attack of erysipelas. She had since had many attacks, each being slighter than the last. She now has solid oedema over the same area as the present case. He had not seen her recently, but was anxiously looking out for her, because he thought it possible that some benefit might be brought about by using a vaccine. His intention was to determine whether her opsonic index for streptococcus was particularly low, and if so, to try what a vaccine would do for her.

Mr. STUART-Low said he had had a little boy in hospital who had a unilateral condition similar to the present case. He had purulent rhinitis on that side. That gradually diminished. It lasted six weeks. Frequently erysipelas of the face was traceable to sepsis of the nose, and it was possible that other cells in the nose might have a septic condition.

Dr. SCANES SPICER said the distribution on the face reminded him of cases of lupus erythematosus, but he hesitated to offer any suggestion that this case might be akin.

Dr. DAVIS did not regard the case as one of erysipelas at all. He had seen many such cases and they had repeated attacks. Some years ago he had shown a girl with the same trouble, where the antra had been drilled before on the supposition that the disease originated there, but it made no difference. He did not think there was such a disease as chronic erysipelas—one would not think of notifying each attack as erysipelas. Women were subject to this condition at their periods, and seemed none the worse in general health.

Dr. JOBSON HORNE agreed with Dr. Davis that it was not wise to put such cases down as chronic erysipelas. Some years ago he looked into those cases of chronic oedema, and found that very little had been written

on the subject. No attempt had been made to classify the cases, but from the fragmentary reports they all seemed to have one or two points in common. They were chronic, long-standing cases, very difficult to do anything for, and none of them had anything the matter with the interior of the nose, therefore they were distinct from the cases referred to by Mr. Stuart-Low. He believed they were brought about by a specific infection, and thought the site of it was intra-nasal.

Dr. DAVIS regarded it as angeio-neurotic oedema.

Dr. JOBSON HORNE considered it belonged to a group of cases distinct from angeio-neurotic oedema.

Mr. ROBINSON said in regard to lymphangitis he had now in the hospital a boy with some puffiness below his eyes. He also had chronic enlargement of the glands in the neck. He removed those freely, and for the next few days there was a marked increase of the swelling in that region. He considered there was some lymph-obstruction causing the thickening.

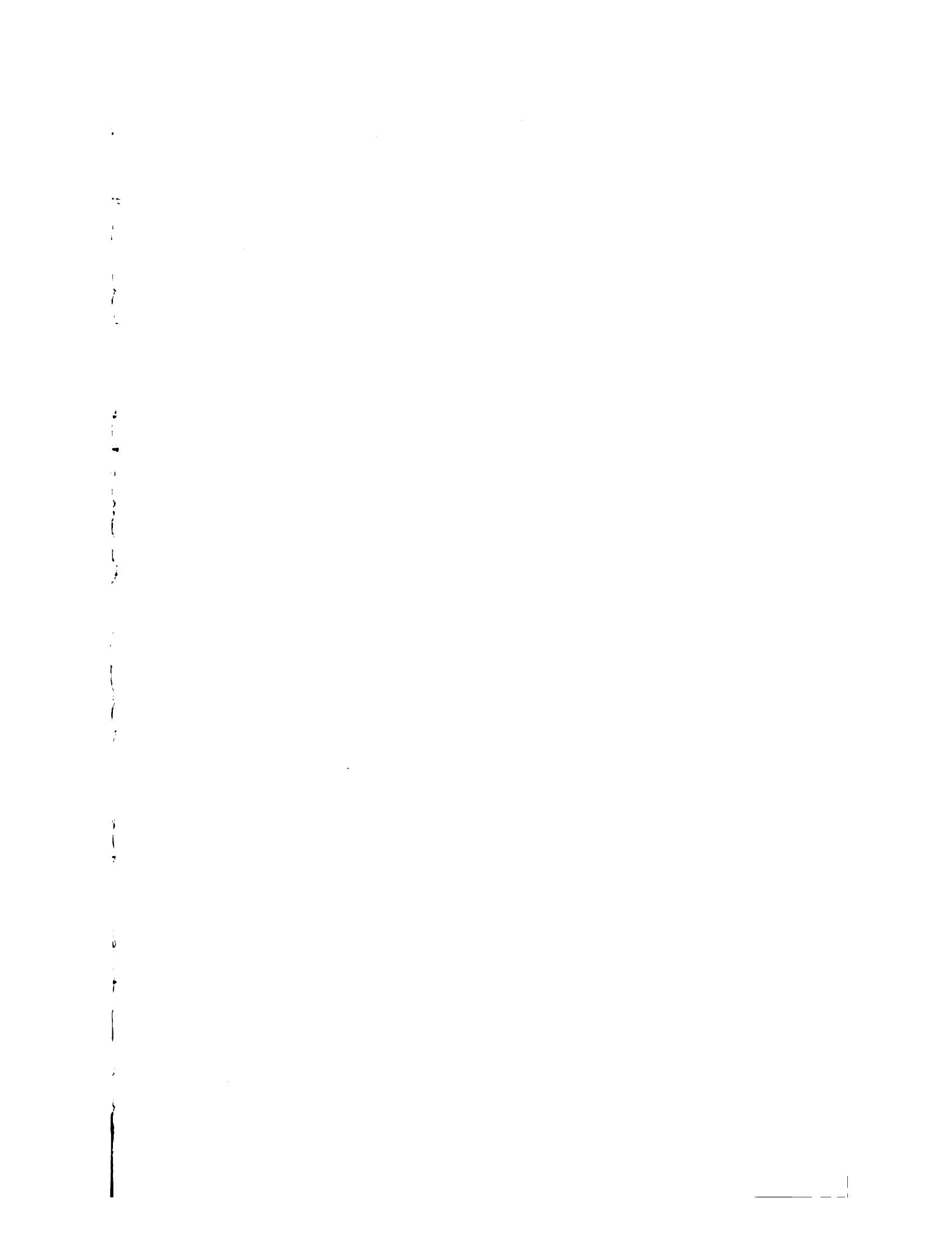
The PRESIDENT said he also had seen many cases of the kind, and had been in the habit of calling them lymphangitis, assuming in the majority of them some infection. They seemed very like the cases occurring about the alæ of the nose and upper lip, which were often associated with cracks in the skin just under the anterior nares, and these cases were cured by attention to the skin lesions. He had not been able to trace any similar cause for cases like that exhibited to-day, but had looked upon the condition as septic.

Dr. HERBERT TILLEY, in reply, said that, as far as he could see, there was no disease in the nose. The patient had been to many skin cliniques in London, but the dermatologists seemed to have been unable to make a diagnosis, though they did not regard it as lymphangitis. He thought he would try the administration of lactate of lime, as suggested by Dr. Grant, on the principle of "any port in a storm." If that did not succeed he would see what antistreptococcal serum would do. Those who said the condition was chronic erysipelas had the satisfaction of knowing that it was the patient's own diagnosis.

A CASE OF CHRONIC FRONTAL SINUS SUPPURATION, RADICAL OPERATION, WITH IMMEDIATE CLOSURE OF WOUND.

Shown by Dr. HERBERT TILLEY. The patient, a male aged twenty-two, complained of a foul, purulent, nasal discharge "since he was a boy." On examination there was seen a purulent discharge from the right middle meatus and small polypi in the same situation. Pus was easily washed from the right frontal sinus, and also from the corresponding antrum.

The front wall of the sinus was removed and also the diseased mucous membrane. A large opening was made into the nose, and the external wound was sutured. There is now no deformity and no secretion of pus in the right nasal cavity. As there was little ethmoidal disease Killian's operation was not considered necessary in this case.





PROCEEDINGS OF THE LARYNGOLOGICAL SOCIETY OF LONDON.

One Hundred-and-tenth Ordinary Meeting, January 4, 1907.

J. B. BALL, M.D., *President, in the Chair.*

HENRY J. DAVIS, M.B., }
W. JOBSON HORNE, M.D., } Hon. Secretaries.

Present—25 members.

The minutes of the previous meeting were read and confirmed.

The following communications were made :

Dr. WATSON WILLIAMS showed stereoscopic skiagrams of the nasal accessory sinuses, from the lateral and transverse aspects, revealing the presence of pus in some of the cavities.

A CASE OF SUBMUCOUS RESECTION OF THE SEPTUM IN A MAN AGED THIRTY-SEVEN.

Shown by Dr. STCLAIR THOMSON. The operation was made from the free end of the quadrilateral cartilage. The specimen showed a large maxillary spine and a high deviation with a vertical ridge. The marked external disfigurement had been improved by the operation.

A CASE OF SUBMUCOUS RESECTION OF THE SEPTUM IN A BOY AGED FIFTEEN.

Shown by Dr. STCLAIR THOMSON. The specimen showed a large maxillary spine and a vertical bony spur removed from far back in the nose.

The PRESIDENT said the results appeared to be very satisfactory.
Dr. E. A. PETERS asked Dr. Thomson whether he intended to make
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a further resection of the nasal bones, so as to remedy the bony defect and give credit to the cartilaginous septum.

Dr. SCANES SPICER said in the cases shown the procedure had been carried out with great thoroughness. He thought Dr. Thomson and he had converted each other on the question of general *versus* local anaesthesia. At a meeting of the Royal Medical and Chirurgical Society in June he (Dr. Spicer) said he had never succeeded in completing a case to his satisfaction except under a general anaesthetic; but since July 1, 1906, he had done twenty-two cases with only local anaesthesia, which he found answered perfectly, and he understood that Dr. Thomson was reverting to general anaesthesia. The operation was necessarily a long one in most cases, but much time was saved by local anaesthesia as compared with general. He had never succeeded in getting away such a large piece of bone in one piece as Dr. Thomson had shown in one of these cases. He now provided himself with Wood's and Heath's septum forceps, chisels, and a Heath's big mallet, and felt that with these any bone could be effectually dealt with. He deprecated hurrying the operation so as to get it done in something like twenty minutes at the cost of thoroughness. Of course it was necessary to psychologise the patient to the extent of convincing him that he would not be caused pain, which was in truth the case. He now always rubbed in (as recommended by Otto Freer) solid cocaine powder at first, and frequently repeated it during the operation, asking the patient to warn him if he felt anything like a suspicion of approaching pain.

Dr. H. SMURTHWAITE said that eighteen months ago he read a paper on thirty-seven cases which he had done without once using general anaesthesia. He could bring up pieces of bone which he had removed as large as a florin. Naturally, neurotic patients were difficult. The object was to do one's best for the patient, therefore why should it matter whether the operation took twenty minutes or an hour? The improved instruments and technique would gradually lessen the time necessary. Novocain or eucaine could be injected under the perichondrium, and in the majority of cases the operation with adrenalin could be done bloodlessly. One heard of deaths under chloroform during operations on the nose and throat, and from that point of view also local anaesthesia was best. Women were not excepted; they sometimes stood it better than did men.

Dr. FITZGERALD POWELL thought Dr. Smurthwaite's experience hardly corresponded with the greater number of the members who had been in the habit of doing this operation. In his own case he found it much easier to do the operation under a local anaesthetic, when one had a good view of the field of operation and was not interfered with by the movements of the patient and the bleeding which was induced by the anaesthetic. Speaking generally, men bore the cocaine in local anaesthesia better than most women and boys, who were usually very nervous and liable to collapse from the effects of the cocaine, and when doing the operation in a sitting posture it was not uncommon to have the patient falling forward in a fainting condition. He thought a general anaesthetic better for most women and boys.

Dr. FURNISS POTTER said he had had some experience in performing these operations both under general and local anaesthesia, and gave his opinion unhesitatingly that where possible cocaine was much to be preferred to a general anaesthetic. The fact of the patient being under a general anaesthetic handicapped the operator considerably, owing to

mopping out of the throat and altering the position of the head. He had not found women or boys to be any exception if it were explained to them that they would not have to endure pain. He was in the habit of using a Thudicum's speculum with long but not fenestrated blades. He objected to the speculum referred to by Dr. Tilley because the fenestrations allowed the mucous membrane to bulge through and narrowed the field of view. The speculum he used was of a pattern suggested by Dr. StClair Thomson with two-inch blades—non-fenestrated.

Mr. HERBERT TILLEY thought there was an advantage in using fenestrated specula in a very narrow nose, because larger forceps could then be passed into the nasal cavities. He selected the form of anaesthetic according to the temperament of the patient. Though there might be no pain with local anaesthetics, some people were continually fidgeting, and no amount of persuasion seemed to diminish their alarm, and no anaesthetic had yet been invented which would allay this mental perturbation. In administering local anaesthetics he applied a 10 per cent. solution of cocaine in the form of a spray first of all, before puncturing the mucous membrane to inject eudrenine. After injecting the mixture of eucaine and adrenaline chloride (eudrenine) he waited ten minutes, and then was able to do the operation without being hampered by oozing of blood.

Dr. STCLAIR THOMSON, in reply, said he would like to improve the nasal bone of one of the patients, and perhaps some member would suggest how it should be done, whether from the outside by turning up a flap, or entirely from the inside. He had only had one or two such cases. In one he turned a flap up from the side of the nose and chiselled the bone away. The scar barely showed afterwards. He formerly operated on such cases under chloroform, because he thought people would not believe in the power of cocaine. Then he started with cocaine, and did thirty cases under it. The difficulty mentioned by Dr. Tilley in the case of nervous patients was a real one, and hampered the operator; they were particularly terrified at the sight of the chisel and mallet, despite the surgeon's assurances. One private patient still blamed him for having done the operation under a local anaesthetic. It was easier to do so. But with a really skilled anaesthetist the operation could be done as well and as bloodlessly under chloroform as under local anaesthesia. He advised operators not to use chloride of ethyl, or gas, or the least suspicion of ether. He operated with the end of the table well raised; it was quite easy to operate with the patient in a reclining posture. He had used the various instruments referred to, but where there was a big maxillary crest he had not been successful with anything but a Killian's chisel. With regard to time, one could get up to removal of cartilage in fifteen to twenty minutes. He had used Ballenger's knife ever since he saw it described. But he could not get a good pattern of it in England. Instead of being stirrup-shaped it should be V-shaped in the middle, so that it would cut out more bone than his did. Perforations afterwards were practically unknown. One of the patients shown was under cocaine forty-five minutes; the other was under a general anaesthetic two hours, but the actual operation did not occupy more than fifty-five minutes, as the patient took the anaesthetic very badly and the administrator was not particularly skilful in this sort of work. The really difficult part of the operation was the removal of the maxillary crest and of bony spurs situated far back. It was to illustrate the results in such cases that these two patients were shown.

A CASE OF CYST IN THE FLOOR OF THE NOSE.

Shown by Mr. C. A. B. HORSFORD. The patient, a woman aged forty-five, presented a cyst in the left floor of the nose, beneath and pushing up the left inferior turbinate body. She was unaware of its presence. There was a history of repeated "gumboils" over the left lateral incisor tooth up to five years ago, when a decayed tooth broke off; the stump was extracted six months ago. The right nasal cavity was atrophic.

Dr. SCANES SPICER said he had seen three cases apparently like the present one. The third one he incised three or four times from the nose, and it had filled up every time. Then he attacked it from under the lip, scraped the cyst out, and packed, and it got well at once. He thought it must have been dental in origin.

Mr. BETHAM ROBINSON suggested that the carious tooth should be extracted, and that boring should be done through the fang. With a little enlargement of the opening he thought it would drain and heal up all right.

Dr. HORSFORD, in reply, said he had hoped to hear whether it was necessary to do anything for the condition; the patient had had no symptoms and no obstruction was caused. Some time ago he removed the stump from the lateral incisor.

CYSTOMA OF THE LARYNX.

Dr. JOBSON HORNE exhibited macroscopic preparations illustrating cystic disease of the larynx. One specimen presented a cyst in the usual situation, namely the lingual aspect of the epiglottis. The tumour, which was relatively of a large size, had occasioned no symptoms during life. The preparation had been made by the formalin method, and the clinical appearances of the cyst had been well preserved. Another specimen showed a condition over one arytenoid region which clinically simulated a cystoma, and from which it had to be differentiated, the condition being occasioned by oedema and not by the obstruction and subsequent distension of a gland-duct as in true cystoma. The specimens were of special interest in connection with the case shown by Dr. Cathcart at the previous meeting.

A CASE OF TUMOUR OF THE PALATE.

Shown by Dr. W. H. KELSON. The patient, a woman aged sixty-five, had noticed a tumour of the palate about six or eight weeks, but thought it had probably existed longer. Five or six

years ago she had had stumps of teeth taken out near to the origin of the tumour.

On examination a button-shaped tumour about an inch in diameter was found at the junction of the hard and soft palates on the right side, extending inwards from the alveolar margin; it was firm in consistency and movable on the subjacent structure, and the mucous membrane, though tightly stretched, was movable over it. No enlarged glands were to be felt.

Mr. P. DE SANTI thought it was simply a fibro-adenoma, and that it would shell out easily.

Dr. H. SMURTHWAITE said he removed, a year ago, a similar tumour from a woman who had had it ten years. A circular incision was made, the finger placed under it, and it shelled out. A section was made, and it was found to be fibro-adenoma.

Mr. ROBINSON inclined to the view that it was an endothelioma.

The PRESIDENT said that in the case which he showed two meetings ago the tumour was larger and much more fixed. The woman refused to have any operation done.

Dr. JOBSON HORNE said that some years ago he had had a case which presented similar clinical appearances; the tumour came away quite easily. He was unable to say, without reference to notes, what its precise microscopic appearance was. He hoped Mr. Kelson would allow members to see a section of the tumour in his case after removal.

Mr. KELSON said, in reply, that though opinions as to the nature of the tumour varied, there seemed to be agreement as to the best treatment. He would bring forward the specimen. The patient said she had noticed it for quite six weeks.

A CASE OF ULCERATION OF THE EPIGLOTTIS AND OF THE BASE OF THE TONGUE.

Shown by Mr. W. H. KELSON. The patient, a man, aged sixty-nine, had suffered from difficulty in swallowing and loss of flesh of about nine months' duration.

On examination there was found to be a mass in the region of the base of the tongue, involving the epiglottis, in which situation ulceration had taken place. Neither cord moved well. There were a number of enlarged glands in the carotid and submaxillary regions.

Mr. ROBINSON said it was a case of malignant disease of the back of the tongue, creeping back to the epiglottis, with enlargement of glands. There was not any doubt as to its nature, and he did not advise operative procedure.

A CASE OF TERTIARY SYPHILITIC LARYNGITIS IN A MAN AGED TWENTY-NINE ; QUESTION OF TREATMENT.

Shown by Mr. DE SANTI. The patient came to Mr. de Santi's

clinic some six months ago with a history of hoarseness, pain on swallowing, cough, and loss of flesh. On examination the epiglottis was seen to be red, infiltrated, enlarged, and bilobed in shape. A view of the larynx could not be obtained on account of the size and shape of the epiglottis. The appearances and history suggested tubercle, but the patient had a marked condition of advanced tertiary syphilitic glossitis. Examination of the chest and sputum on several occasions was always negative. The patient was put on iodide of potassium, which was gradually increased up to 30 gr. daily, but little improvement followed. He also had a course of iodide of mercury, and also of sarsaparilla, but really never at any time reacted to the drugs used. At one time Mr. de Santi thought there might be mixed infection of tubercle and syphilis, but, having watched the man for some months, was convinced the disease was entirely of specific origin.

He brought the case forward for views as to further treatment. These cases, if left alone, tended to end in contraction and stenosis of the larynx, a condition to be prevented by every means possible.

Dr. STCLAIR THOMSON said one could not get a good inspection of the inside of the larynx, but there was slight ulceration, and the man might have tubercle grafted on to his syphilis. Iodide and mercury had only been given him by the mouth, and no case of syphilitic disease of the larynx should be despaired of until mercury had been given by injection or by inunction. Many such cases resisted treatment by the mouth, and some even did not yield until tracheotomy had been done, thus affording rest to the part.

Dr. A. LIEVEN regarded the case as wholly syphilitic; ulceration must be expected in a case which had persisted so long. Iodide and mercury should not be used at the same time when calomel was injected, as the latter did not agree with the iodide; there was produced much local irritation, and sometimes swelling of the mucous membrane, which might be fatal in such a case as the present. He recommended tracheotomy, to keep the part at rest. In any case it might have to be done later, because of the narrowing of the part due to contraction. That occurred in a case in which the larynx yielded very well to treatment, but the air-passages became so narrow that tracheotomy had to be performed. He used a suspension of 1 part of calomel in 10 of vasenol, a new preparation of paraffin, which was the least irritating vehicle he knew. The dose was half a sixteen-minim syringeful, but a very small dose should be given at first, one third of a syringeful, as the idiosyncrasy of the patient might be intolerant of mercury, and when once it had been injected it could not be got out again.

Mr. DE SANTI, in reply, expressed his gratitude for the opinions expressed, and said he would advise the man to have tracheotomy done and have calomel injections. The patient was very anxious for relief.

A CASE OF LARYNGEAL DISEASE (? SYPHILITIC).

Shown by Dr. J. B. BALL. The patient is a married woman aged forty-seven. She has had ten children, of whom four were stillborn, and she has had one miscarriage, at four and a half months. She states that she has always had good health. She has had some hoarseness of voice for the last six months, and some increasing dyspnœa on exertion for about two months. There are two small scar-like depressions on the soft palate, but she has no recollection of ever having had a sore throat. In the larynx there is a pale glistening swelling situated over the left vocal cord. The appearance of this swelling is consistent with its forming part of a swollen œdematosus cord, or with its being a swelling protruding from the ventricle and covering the cord. There is distinct subglottic swelling on this side of the larynx. The left vocal cord is fixed. The patient was seen for the first time a couple of days ago and has had no treatment.

Mr. HERBERT TILLEY thought the swelling was on the surface of the anterior half of the left vocal cord. Opposite that swelling one could see the right vocal cord, which also seemed slightly œdematosus; it had not the clean-cut appearance of the normal vocal cord. Under both cords could be seen a swelling, which he thought was a subglottic hyperplasia. There was a strong history of syphilis, and he would treat the case from that point of view before actively interfering with the larynx. Indeed, he did not know what active interference could be carried out unless it were touching the swelling on the left vocal cord with the galvano-cautery. This would cause much irritation, and he did not think the result would be a beneficial one.

Dr. FITZGERALD POWELL said in their present knowledge of the history of the case, and the sputum as yet not having been examined, no one could give a very decided opinion as to its nature. There appeared to be a growth coming out of the ventricle and overlapping the cord. He thought the case was most probably syphilitic, but the possibility of tubercle should be considered and the sputum should be examined.

Dr. SCANES SPICER said his own view was that of Dr. Powell, relying on the general appearance of the mass and that the posterior wall was involved at the same time; but he did not feel confident about it.

Dr. STCLAIR THOMSON said there was much subglottic infiltration on both sides and marked subglottic stenosis. He thought the condition of the cords was due to their being pinched by the infiltration going on above and below. He thought it could scarcely be tubercle, because such an extensive deposit of that would have already broken down. The woman required tracheotomy and similar treatment to Mr. de Santi's case. Early tracheotomy tended largely to prevent the scarring and stenosis of which Dr. Lieven had spoken. He had done many cases in which tracheotomy and treatment with mercury, *via* the skin, had saved that stenosis which otherwise would have been likely.

The PRESIDENT, in reply, said he had felt doubtful about the nature

of the case, and even as to what the gelatinous swelling on the left side was. He concluded that it was more or less a part of the left vocal cord. He agreed that there was some subglottic infiltration on both sides. The history pointed to syphilis; she had had four stillborn children and some very early deaths among the children born alive. Also on the soft palate there appeared to be two depressed scars, though she said she had never had a bad throat all her life. He had only just seen the patient, and should have put her upon iodide of potassium at once but for the dyspnoea, which might have been increased by that drug. He did not propose to start with mercurial injections, but would take her into the hospital, and she would probably rapidly respond to syphilitic iodides if the case were syphilitic.

A CASE OF EPITHELIOMA OF LARYNX SHOWN ON NOVEMBER 2 AND DECEMBER 7, AND TREATED BY A VACCINE OF MICROCOCCUS NEOFORMANS SINCE THE FORMER DATE.

Dr. SCANES SPICER again brought this case for inspection by the members of the Society, that they might determine what, if any, progress had resulted in the local growth and general condition. The injections had been continued as before in the Inoculation Department under Sir A. B. Wright. Dr. Spicer's view was that the malignant mass was smaller, and was based on the fact that a much more complete view of the larynx was possible than on the previous occasions. The surface was cleaner, the patient swallowed better, and felt and looked well. In view of the opinion expressed by some members he had taken the opinion of his colleague, Mr. A. J. Pepper, as to the possibility of completely removing the diseased parts, and that surgeon had negatived that possibility with any reasonable probability of success, owing to the extension of the growth on to the pharynx and the glosso-epiglottic fold. That view was the result of experience gained together in several cases during the past eighteen years.

Dr. WATSON WILLIAMS (who had had to leave early) had asked Dr. S. Spicer to state that he considered that at all events the rate of growth over the two months had been very materially retarded, as compared with his previous observation of the case.

Mr. ROBINSON reminded members that when the case was last shown he said that although it was cleaner than before it had increased in size. But he did not think it had increased appreciably since then. If the patient consented to operation, what was to be done? He did not advocate operation. The growth was spreading out in the pyriform fossa and over to the other half of the larynx; moreover there were such marked hard glands that it was not a fit case for operation.

Mr. DE SANTI felt certain that nothing could be done from the point of view of operation. The main consideration in such cases was whether

the whole disease could be extirpated, and if this could not reasonably be done the patient should be left alone. In the particular case under consideration there was not the slightest hope of being able to remove the whole disease.

A CASE OF TONSILLAR DISEASE WITH CONSIDERABLE ENLARGEMENT OF THE CERVICAL GLANDS.

Shown by Dr. C. A. B. HORSFORD. The patient attended hospital on December 6, 1906, on account of soreness on the right side of the throat, of six weeks' duration. Two lumps had been noticed by the patient on the right side of the neck the day before admission ; they were hard and painless. On December 11 the right tonsil was removed; severe haemorrhage followed for a few hours afterwards and recurred five days later. The patient had an attack of shivers two days after the operation, and there had been continuous swelling of the neck since.

Mr. ROBINSON said the question was raised whether the tumour of the tonsil recently removed was syphilitic or not. He did not think there would be such a glandular swelling in the neck associated with chancre. Therefore it must now be considered as to whether there was some very slow phlegmonous condition or a malignant growth. His view was the latter, and that nothing could be done for it. It extended freely down to the side of the pharynx, filling the pyriform fossa on that side. It even spread over the back of the cricoid. It was also very hard, and if it were inflammatory there certainly should be signs of oedema over it.

Dr. LIEVEN thought it impossible to decide whether it was a primary chancre, because that condition tended to heal within two or three months, whether treated or not, and it did not leave a large scar. The sore which it made was not of the tissue it was in, but of its own tissue. But against syphilis was the fact that there were no secondary symptoms; and primary sores were very painful, whereas this man had not experienced much pain. Before operation he would try mercurial inunction for a few days. If no benefit resulted, he would make an incision in case there might be pus present ; but the incision would not settle whether it was or was not chancre.

Mr. DE SANTI agreed with Mr. Robinson as to the nature of the glands. He did not think they could possibly be syphilitic ; they were probably malignant. There was a large, hard, extensive mass of glands, with some tenderness in parts, whereas in the case of a chancre of the tonsil there was enlargement of the glands in the neck which, though very hard, were discrete, as a rule, and movable.

Mr. STUART Low said he had carefully examined the case, and he watched a similar case two years ago, when it turned out to be a deep-seated phlegmon, with pus under the fascia. Dr. Grant operated upon this case. In another case a man came from a hospital, where removal of his tonsil had been carried out, perhaps too thoroughly, and probably the pharyngeal fascia had been wounded, as pus burrowed under the deep fascia. This being softer in the centre than in other parts, and the history being short, he advised incision.

Mr. Atwood THORNE considered that the case was probably malignant, but that it might possibly prove to be merely inflammatory, and that an exploratory incision should be made.

Dr. JOBSON HORNE said it was difficult to express an opinion upon what one had not seen—namely, the original condition of the tonsil. He had seen a precisely similar glandular condition secondary to primary chancere of the tonsil. He would try antisyphilitic remedies before operating.

Dr. FITZGERALD POWELL said it was not possible to say with certainty what the nature of the lesion in the tonsil was, which appeared to be responsible for the enlargement and hard, brawny condition of the glands; it must not be forgotten that in association with this there appeared to be a fairly general infection of the larynx. The arytenoid on the right side and the right cord appeared to have their movement impaired. He thought the condition was due to specific infection; the man was in a very weak condition, very pale and anaemic. He should be kept in bed, fed up, and put on anti-syphilitic treatment in combination with iron. If the case was malignant, it certainly, he thought, was inoperable.

Dr. SCANES SPICER said that, whatever else was done, the teeth should be seen to and the mouth made aseptic.

Dr. DAVIS thought it worth while to make an exploratory incision under an anaesthetic. There might be pus, as apparently there was oedema and deep fluctuation. If the glands were inflammatory, the trouble would be likely to extend into the larynx. He lately saw in hospital an urgent case of a man who had inhaled a husk while chaff-cutting. The foreign body had probably lodged in the pyriform fossa, but was invisible. There was great oedema under the chin and distortion of the larynx, but it was simply inflammatory oedema. He advised the application of three or four leeches to the part.

Mr. HERBERT TILLEY said he had heard there was an evening rise of temperature, suggesting that the swelling might be of an inflammatory nature. In view of the differences of opinion expressed, he thought it would be most instructive if the after-history of the case could be brought before a future meeting of the Society.

Dr. HORSFORD, in reply, said that a week ago the appearance suggested syphilis. He had seen a similar case in a girl who had a sloughy-looking unhealthy ulcer on the tonsil, with a large swelling of the glands, and she later developed secondary symptoms. It was not more than eight weeks since this man complained, so that there had scarcely been time to exclude the likelihood of secondaries appearing. He believed it was primary syphilis, the unhealthy tonsils accounting for the two attacks of haemorrhage after the operation and the increased swelling of the neck—a septic complication—it had been too acute for a malignant condition.

THE SPECIMEN FROM A CASE OF FIBROMA OF THE LARYNX SHOWN AT THE MEETING ON DECEMBER 7, 1906.

Shown on behalf of Dr. G. C. CATHCART by Dr. JOBSON HORNE. In the absence of Dr. Cathcart, Dr. Horne said that subsequent to the last meeting he had been asked by Dr. Cathcart to see the

case with him with a view of deciding upon the course of treatment to be adopted. Upon a more thorough examination under cocaine it became apparent that they had to deal with a very tough and solid tumour attached by a very broad base to the summit and outer aspect of the ary-epiglottic fold, the cystic appearances subsiding under cocaine. It was decided not to attempt a removal by means of an endo-laryngeal operation. The tumour was successfully removed through an external incision, and was now exhibited to the Society.

The PRESIDENT reminded members that every one seemed to have seen the case last time, but nobody suggested it was not a cyst, yet it now was shown to be a solid tumour.

Dr. FITZGERALD POWELL asked whether the singing voice had suffered by the removal. He did not think it would.

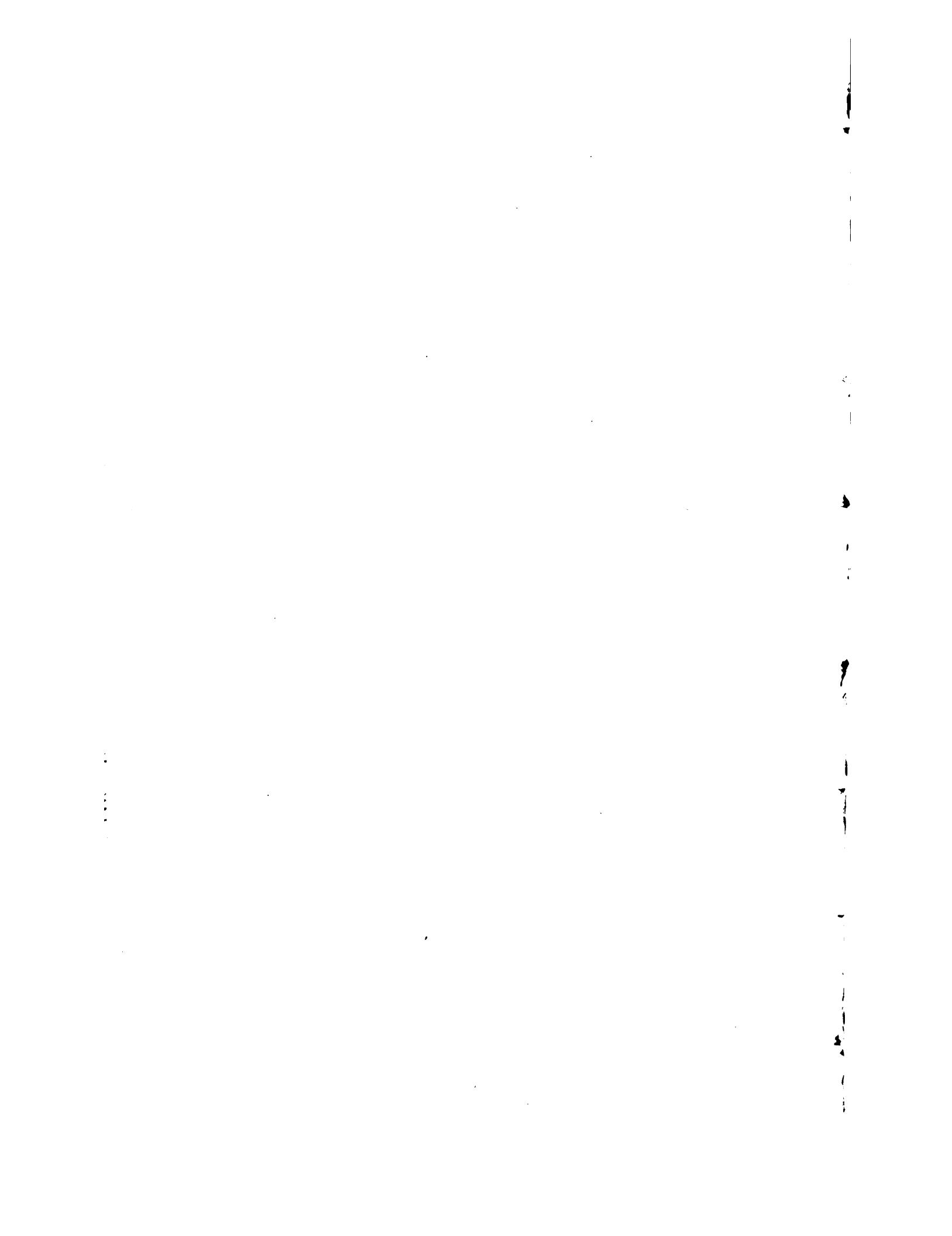
Mr. ROBINSON asked whether members could be told what form of external operation was done.

Dr. ATWOOD THORNE asked if the patient and the specimen could be shown later.

Dr. JOBSON HORNE explained that Mr. Cathcart was away, and no doubt he would report more fully on his return.

SPECIMENS OF CARTILAGE AND BONE REMOVED BY SUBMUCOUS RESECTION OF THE SEPTUM.

Mr. HERBERT TILLEY showed a number of specimens which illustrated the ease with which the deviated cartilage could be removed with Ballenger's swivel knife. Luc's ethmoidal forceps with fenestrated blades were shown and recommended for the removal of the ethmoid and vomerine irregularities. A large self-retaining fenestrated nasal speculum after the Thudicum pattern was exhibited; it was very useful for keeping aside the flaps of mucous membrane while the bony portion of the deviation was being removed.



PROCEEDINGS OF THE LARYNGOLOGICAL SOCIETY OF LONDON.

One Hundred and eleventh Ordinary Meeting, February 1, 1907.

J. B. BALL, M.D., *President, in the Chair.*

HENRY J. DAVIS, M.B. }
W. JOBSON HORNE, M.D. } Hon. Secretaries.

Present—26 members and 1 visitor.

The minutes of the previous meeting were read and confirmed.

The following gentlemen were elected as ordinary members:

H. B. TAWSE, M.B.Aberd., F.R.C.S.
HENRY CURTIS, M.D.Lond., F.R.C.S.

The following communications were made:

A CASE OF FIXATION OF THE LEFT VOCAL CORD IN A WOMAN, AGED FORTY-FIVE.

Shown by Dr. FURNISS POTTER. The patient was a single woman and a teacher, who stated that fifteen years ago she had had a goitre removed at St. Thomas's Hospital, that she had known the "left side of her larynx had been paralysed" for at least the last four years, and that she had lost her voice a year ago, comparatively suddenly—*i. e.*, she felt it to be weak one day, and within a few hours lost the voice completely, being reduced to speaking in a whisper. This had continued up to the present, and was the only symptom complained of. She had, however, conceived the idea that she had a growth in her larynx, and it was for this that she sought advice.

Laryngoscopic examination showed that the left cord was fixed in, or near, the middle line. The right cord was freely movable, but repeated attempts to make the patient phonate failed to elicit any nearer approach to voice production than a grunt, or to bring the right cord into apposition with its fellow, although it came into close approximation. The region of the left arytenoid was distinctly swollen as compared with the opposite side.

Examination of the chest revealed signs indicating old tuberculous trouble in the right upper lobe, but no evidence of present active mischief. It was stated by the patient's medical attendant that she had lost flesh during the last few months. Potassium iodide had been administered for a fortnight, but with no appreciable result.

Dr. Potter was inclined to the opinion that the aphonia was functional in character. He took this view because of the history, and because he did not consider that, from the appearances in the larynx, there was physical reason sufficient to account for such absolute loss of voice.

As regards the fixation, injury to the recurrent nerve on the occasion of the removal of the goitre was a possibility to be thought of, but he, personally, would suggest that the fixation was due to old tuberculous infiltration round the crico-arytænoid articulation, which had been arrested and replaced by fibroid material, with consequent locking of the joint.

Mr. BETHAM ROBINSON said he considered that the want of approximation and the air waste were due mechanically to the position of the cartilage of Wrisberg. When the cord tried to come over, it impinged on the cartilage of Wrisberg, which was in front of the one on the other side; and when the patient tried to phonate, the air waste was obvious.

Dr. F. W. BENNETT thought it was probably the result of an old paralysis of the cord, and the aphonia was due to the cords not coming into contact. Possibly the difficulty in approximating the cords was due to the debilitated condition of the patient. He suggested that perhaps the paralysis of the cord dated from the time of operation, but that until the more recent impairment of general health, the patient was able to bring the cords sufficiently into contact to produce clear vocal tone.

The PRESIDENT said he presumed that the term "fixation" was meant to include the result of paralysis. No doubt the left vocal cord was fixed by paralysis, but the question Dr. Potter raised was: why was her voice so much weaker than in most cases where one cord was paralysed? He believed Dr. Potter referred to an operation which had been performed.

Dr. POTTER, in reply to questions by the President, said he used fixation as a general term. The fixation he looked upon as the point of interest in the case, together with the aphonia. The patient had a goitre removed fifteen years ago, but had suffered from loss of voice during the last year only.

The PRESIDENT thought it most likely that Dr. Bennett's suggestion was correct. He believed the present weakness of the voice to be functional. There was not such good approximation of the cords as there should be. The cough was fairly loud, though gruff, and, during coughing, he thought it likely she brought the cords closer together than when asked to phonate.

Dr. H. SMURTHWAITE suggested that, following the operation for the removal of the goitre, adhesions had been left, and that the recurrent laryngeal nerve had become involved in them.

Dr. DUNDAS GRANT thought there must be something more than paralysis of the left vocal cord, because the rule was that, as time went on, the voice improved, through the compensatory action of the muscles on the other side bringing the healthy cord over the mid-line. He greatly favoured the idea that the vocal condition was now functional. Having been told that the vocal cord was paralysed, the patient might have an impression that the voice ought not to be operative.

Dr. POTTER, in reply said that he could hardly think that the prominence of the cartilage of Wrisberg would interfere to such an extent as to completely prevent phonation. Looking at the swollen condition of the arytenoid region, it was reasonable to suppose that this had been the seat of tuberculous infiltration, which, like the lung trouble, had been arrested in its progress, and that the crico-arytenoid articulation had been locked by fibroid material. He was much inclined to look upon the aphonia as functional. The patient stated that she had lost her voice comparatively suddenly. She had noticed it to be weak one afternoon, and within a few hours had completely lost it. He (the speaker) had seen the right cord come very nearly into apposition with its fellow, and did not think there was sufficient mechanical obstacle to prevent phonation. He had applied the Faradic current, but had failed to make the patient phonate. Notwithstanding this, he adhered to his opinion that the disability was functional, and that with perseverance the power to use the voice might be demonstrated.

A CASE OF TUMOUR OF THE NASAL SEPTUM.

Shown by Dr. FURNISS POTTER. The patient was a married woman, aged thirty-one, who had complained of increasing nasal obstruction on the right side for the last year, with occasional slight bleeding, chiefly on blowing the nose. On examination a red, vascular, sessile tumour was seen, about the size of a horse-bean, on the right side of the anterior part of the septum. It was soft, easily pierced by a probe, which produced some, but not profuse, bleeding. It was suggested that the growth belonged to the group described as "bleeding polypus of the septum."

Mr. C. A. PARKER thought that if cocaine were applied and a good view obtained, the inferior turbinal would be seen to be also involved. He regarded it as tuberculous infiltration of the nature of lupus.

The **PRESIDENT** thought the condition was extensive, and went a long way back. The septum was deflected to that side. If, as Mr. Parker thought, the lower turbinal was also involved, anything like scraping would be sure to cause adhesions. He suggested doing what he did in a case of lupus a few years ago. The septum was deflected and the passage was very narrow on the affected side, and both the lower turbinal and the septum were affected with lupus. He removed the diseased mucous membrane of the septum and the deflected cartilage, leaving the mucous membrane of the opposite side intact, thus correcting the septal deformity. He scraped the diseased lower turbinal. No adhesions resulted.

Dr. STCLAIR THOMSON thought there could scarcely be any doubt that it was lupus. He suggested the value of applying adrenalin. If that

were placed over a lupus surface like the present the tissue was rendered anaemic, except at the deposit, and then it stood out as a distinct apple-jelly mass. He came across that in a girl who had lupus of the inferior turbinal. She had a deviated septum, and in the out-patient room it was thought to have a normal appearance. Having, it was supposed, arrested the lupus of the inferior turbinal, she had adrenalin and cocaine applied before resection, and then the "apple-jelly" infiltration became so distinct that he did not operate, as lupus was one of the contra-indications to septum resection given by Killian. He had watched her since, and the condition had developed. He would like to hear whether there was any recurrence in the President's case. He suggested the application of the galvano-cautery as an alternative treatment, not applied over a large surface, but applied deeply at several points, so as to produce scar tissue.

The PRESIDENT, in reply to Dr. StClair Thomson, said that, so far as he knew, there had been no recurrence. He saw the patient a few months after the operation, but that was five or six years ago. He was not aware of there being any contra-indication. In the present case, whether one used the galvano-cautery or any such treatment, he thought there were sure to be adhesions, unless the deformity of the septum were corrected.

Dr. POTTER, in reply, said that his own opinion had been divided between tubercle and "bleeding polypus," but his inclination had been rather towards the latter. He intended to remove the growth, together with the cartilage underlying it, by a submucous resection, *i. e.* by dissecting off and preserving the mucous membrane of the opposite side of the septum—in fact, what was known as the Krieg Boenninghaus operation. He proposed to do this, in spite of Dr. StClair Thomson's caution as to possible recurrence. The affected part was clearly circumscribed, and could be completely removed. He, the speaker, had not observed anything abnormal in the inferior turbinal.

A CASE OF A LARGE TUMOUR IN THE SOFT PALATE AND THE LEFT
WALL OF THE PHARYNX; OPERATION JANUARY 15; SPECIMEN;
MICROSCOPIC SLIDE; PATHOLOGICAL REPORT.

Shown by Mr. STUART Low. He said that this woman, aged sixty-five, came to the hospital complaining of some pain in the throat and difficulty of swallowing, which had increased very much during the last fortnight. She had been conscious of some obstruction existing in her throat for about eighteen months, but this had become much more marked since six weeks ago. There was no swelling nor glandular enlargement to be felt from the neck. The tumour was seen to occupy the whole of the left half of the soft palate and half of the right side, and was incorporated with the palate from the middle of the left half right over to the right side. It also occupied the left side of the pharynx between the palatal pillars. The swelling was very firm in consistency, and the soft palate was stretched over it.

At the operation for removal laryngotomy was first performed,

as the tumour seemed fleshy and vascular, and free haemorrhage was anticipated; the pharynx was then firmly plugged with sponges. Having split the soft palate longitudinally the tumour was shelled out from the pharyngeal wall, but had to be dissected away from the structure of the palate, to which it was found to be firmly attached. There was considerable haemorrhage. Three stitches were inserted into the soft palate, and the laryngotomy tube removed at once. She made an uninterrupted recovery.

REPORT BY DR. WYATT WINGRAVE.

"The growth is a typical endothelioma, consisting of a homogeneous stroma, enclosing groups of cells, which are arranged in cylinders (hollow and solid), becoming alveolated and fused. In some parts they have a laminated arrangement, and are calcified. There are no marked mitotic changes in the nuclei. In texture the growth was soft and friable, except in one part, which was firm and tough owing to excess of stroma. It is fairly vascular and encapsulated."

Mr. ROBINSON thought there was no doubt that it was endothelioma. It showed definite cells round the vessels, and in places there was mucous softening, such as one found in similar tumours of the parotid.

A CASE OF LARYNGEAL TUBERCULOSIS.

Shown by Mr. BETHAM ROBINSON. The patient, a woman aged thirty-one, married ten years, had had frequent loss of voice in winter for ten to fifteen years. Now hoarseness for one year, with some dry cough, and only a little watery expectoration. She had got thinner lately, but otherwise felt and looked well.

The larynx showed a thickening posteriorly, with almost symmetrical warty granulations in the interarytænoid region. Some discolouration of both vocal cords, the right one being irregular. The epiglottis was normal. There were no physical signs in the chest. She has had six children, of which only two are alive, the rest dying shortly after birth. There had been one miscarriage. Before coming under Mr. Robinson's care she had been treated with potassium iodide, on the supposition the condition was syphilitic, but without any improvement. Her father had phthisis.

Mr. H. BARWELL thought the appearance was very suspicious of tuberculosis. There was a large, shiny, pale, œdematosus-looking swelling of

the right cord, as well as the pale outgrowths in the interarytænoid space. It often happened in such cases that no physical signs could be detected for some time; and one could not diagnose the absence of tubercle in the chest without observing the temperature for some time, and watching the weight, as well as examining physically.

Dr. W. H. KELSON thought the possibility of it being papilloma should not be lost sight of, considering that no tubercle bacilli had yet been found, and that the lungs showed nothing. She seemed to have a very fair voice, and, for the quantity of the growth, if it were tubercle he did not think the voice would be so good, and he would have expected more infiltration.

Dr. ATWOOD THORNE thought it would be a mistake to rush to the conclusion that it was tubercle. The two little white, currant-like bodies in the interarytænoid space were the chief feature in the case; there was nothing suggestive on either cord.

The PRESIDENT said he thought there was some swelling of the right vocal cord.

Dr. STCLAIR THOMSON thought it would be a great misfortune if it were not concluded that the case was tubercular. That interarytænoid appearance in a woman who was not syphilitic, and not a drinker, was characteristic of tubercle. There was distinct infiltration of the vocal cord and loss of substance over the vocal process; she was losing weight, felt weak, and sweated a good deal. He thought the case should be at once treated on the assumption that she had tuberculosis.

Mr. ROBINSON, in reply, said his remark about tubercle bacilli was that the report had not yet been received, not that the bacilli could not be found. He had noticed the swelling of the right vocal cord, which increased the probability that it was tubercle.

NOTES ON THE PROGRESS OF A CASE OF ADENITIS SHOWN AT THE PREVIOUS MEETING, JANUARY 4, 1907.

Report by Dr. P. H. ABERCROMBIE. The case proved to be one of deep-seated abscess. On January 12 the swelling in the neck was incised, and fully half an ounce of pus escaped, in which Dr. Wyatt Wingrave found the *Streptococcus pyogenes*. The following are the notes of the case: The patient, aged forty-nine, a tobacconist by trade, was seen at hospital on Thursday, December 6, 1906. He complained of "sore throat," confined to the right side and low down, and also of "pain on swallowing" of about six weeks' duration. He knew of no cause for his throat affection. In spite of treatment his throat did not improve, but rather tended to get worse, and when first seen the tonsils were enlarged, especially the right one, which latter presented the appearances of chronic lacunar disease. The uvula was very long, and the teeth were far from clean. At this time there was no lymphatic glandular enlargement. There was some degree of nasal obstruction present from septal deviation. The

removal of the tonsils and shortening of the uvula was advised, and five days later (December 11) this was carried out. On the morning of the operation day the patient drew attention to two hard, painless swellings, evidently glandular, near the angle of the jaw on the right side, and which he had first noticed only a day or two before. On his return home from hospital a few hours later he bled a good deal, and he again lost blood five days after this, when he had an attack of "shivers," followed by sweating. On December 22 (*i. e.* eleven days after the operation) he went out for the first time, and he returned to business on December 24. The throat, however, never got quite well and he came to hospital on January 3, when the glandular enlargement was very much greater, and the right tonsillar region was swollen, red, and unhealthy-looking. There was also considerable œdema affecting the right side of the larynx (epiglottis, aryepiglottic fold, arytaenoid, and ventricular band) and interfering with the action of the right vocal cord. The temperature was 99° F. Dr. Abercrombie considered the condition was a septic one, probably coccal, and that the dirty state of the teeth might explain the source of infection. A swabbing from the right tonsil region was examined by Dr. Wingrave, who reported: "Agar inoculation from fauces afforded pure growth of *Streptococcus pyogenes*." The patient entered the hospital as an in-patient on January 4, when his temperature was 97° F. The next day it reached 99·8° F., the following day 101·4° F., when he developed in his left great toe-joint what he called "gout," and what certainly answered to the usual description of such given in the books. In addition to this, however, he had pain in the right ankle, which he described as being different from "gouty pain." The day following this the temperature was 102° F., and for the next few days it kept between 100° F. and 101° F. On January 10, at 4 p.m. (four hours after the patient's dinner), Dr. Wingrave examined his blood and reported that "no bacteria were found; the blood count showed leucocytes at 4500 per cubic millimetre." This is noteworthy, considering the fact that pus must have been present in the neck at that date. Two days later (January 12) an incision was made into the swelling, and quite half an ounce of pus escaped. This was examined by Dr. Wingrave, and was found to contain the *Streptococcus pyogenes*. The day following he sweated profusely, but there was no rigor, nor did he have any shivering attack during his residence in hospital. On the 15th the temperature suddenly shot up to 104° F.; he again perspired very freely, and he complained of some difficulty and pain in swallowing, with

slight obstruction to breathing. The laryngeal oedema had increased considerably, so much so, indeed, that it was thought tracheotomy might be required. It was found to be necessary to make a counter-opening lower down in the neck to ensure better drainage. Next day he was much better and perspired freely. The dyspnoea had gone. He swallowed quite comfortably and his temperature had subsided. On the 20th (four days later) he was suddenly attacked with acute pain in the right wrist, which was regarded as evidence of septic arthritis. Anti-streptococcic serum was then used. He had four injections in all, two on January 21 and two on the 22nd, each injection consisting of 10 c.c., but the benefit from this was not very marked. He has progressed favourably, if slowly, since then, and he is now convalescent, and will soon be able to leave hospital. With regard to his past history, his only trouble appears to have been "gout," of which he says he has had about twenty attacks, the first one being in 1833, when the left great toe-joint was the one involved. Since then he has had an attack, always in the same joint, about once a year, and usually in the spring. In this connection it is interesting to note that he has always consumed a good deal of malt liquor, and has been in the habit of eating butcher's meat twice a day. He smokes at least 3 oz. of tobacco a week. He has never had any form of venereal disease, and apart from his "gout" he has always been a very healthy man. He admits having neglected his teeth, and their appearance certainly confirmed this statement. Dr. Wingrave again examined his blood on January 22—ten days after the opening of the abscess—and again failed to find any streptococci, but there was on this occasion a marked increase in the number of leucocytes—14,500 per c.m. (3 p.m.). In the deposit round the teeth were found Spirochaete dentium, streptothrix, diplococci, and yeasts in great abundance. While in the hospital the patient took quinine and iron. The teeth and gums were cleansed with a 1 per cent., warm solution of lysoform, and the tonsillar region was painted daily with menthol in almond oil (20 per cent.).

With regard to the suspicion of malignant disease, Dr. Abercrombie thought the short course of the affection, viz. about two and a half months, was against this view. As to syphilis, no secondary symptoms have appeared, and a course of mercury, prescribed by his medical attendant, produced no beneficial effect; indeed, during its administration the throat steadily got worse. When the patient was first seen his medical attendant thought it might be a case of herpes of the tonsil, as there were several spots

which looked like ruptured vesicles, and the swelling was slight but the pain great.

The PRESIDENT said a few of the members at the last meeting held that it was inflammatory, but the majority who spoke believed that there had been a primary sore on the tonsil, and that the adenitis resulted from this.

Mr. ROBINSON said he was pleased to hear what had been the result in the case. He had expressed the opinion that it was malignant, and he had learned something now that it had proved not to be.

Mr. HERBERT TILLEY asked whether there was an actual abscess, or simply points of suppuration in the glands.

Dr. ABERCROMBIE, in reply, said there was an actual abscess. No secondary syphilitic symptoms had appeared, and, during a course of mercury, prescribed by the patient's medical attendant, the throat condition steadily got worse.

A CASE OF ABNORMALITY OF THE NECK.

Shown by Dr. KELSON. The patient, a man, aged twenty-one, complained of his neck growing to one side; he thought there had always been something wrong, but it had become more obvious lately. On examination there was found to be a very marked subcutaneous band passing up from the sternal origin of the right sterno-mastoid; at about the level of the cricoid cartilage it appeared to bifurcate, the inner band being lost in a small, doughy swelling in the region of the hyoid bone, whilst the outer division passed backwards, and was lost under the sterno-mastoid; the position of the head was normal, and no abnormality could be detected by internal examination.

Mr. ROBINSON thought it was a thickening in the fascia coming down from the anterior border of the digastric, and fusing with the cervical fascia over the sterno-mastoid. Why it should be thickened he did not know. He knew of no abnormal muscle which occupied that position.

Mr. STUART-Low thought it was the omo-hyoid muscle. The late Professor Hughes had been particular to point out the vagaries of the omo-hyoid, which had much fibrous tissue in it. Probably there was but little muscle in the present one.

Dr. KELSON, in reply, thought it must remain undiagnosed at present. He could not accept the view that it was sterno-thyroid or sterno-hyoid, because he did not think they were found to arise from the anterior surface of the sterno-mastoid. And one could scarcely imagine any injury at birth damaging the sterno-thyroid and sterno-hyoid without also damaging the sterno-mastoid.

A CASE OF ULCERATION AND INFILTRATION MAINLY CONFINED TO THE RIGHT HALF OF THE LARYNX.

Shown by Dr. DUNDAS GRANT. The patient was a girl, aged twenty-one, who complained chiefly of hoarseness of seventeen

months' duration, which had been preceded by a sore throat for one month with pain in swallowing, this soreness continuing for two or three months longer. She first came under the exhibitor's notice about a month ago, when there was some delicate cicatrisation of the left half of the fauces, producing partial adhesion to the posterior wall of the pharynx. There was some degree of tumefaction of the epiglottis, which was intensely red, and on the under surface could be seen an irregular row of very small, translucent granulations, which probably marked the upper limit of a concealed ulcer. The right aryepiglottic fold was infiltrated, its mucous membrane being very superficially ulcerated, this being continuous with a similar condition on the ventricular band. The vocal cord was irregular in outline, and superficially ulcerated at its posterior part. The probable diagnosis made in the first instance was one of syphilis, and iodide of potassium, in doses of 10 to 15 grains thrice daily, had been given for some time; the pharynx improved to some extent, but the ulceration in the larynx had persisted. There were no confirmatory evidences of a specific infection either acquired or inherited, the only thing suggestive of it being the occurrence of a severe sore throat, which lasted one month when she was twelve years of age. The appearances were compatible with those of lupus, but in view of the possibility of its being specific, and, therefore, amenable to treatment, the exhibitor proposed submitting her to a course of mercurial inunctions, and he was desirous of eliciting whether any of the members of the Society considered it contra-indicated.

Dr. SMURTHWAITE said it gave him the impression that it might be syphilitic, considering the posterior pillar of the fauces on the left side had become adherent to the pharynx, and the scarred condition of the latter; but, on the other hand, a lupus could have produced the same. The laryngeal appearance, with its mouse-eaten condition, favoured the view of tuberculosis. Especially was this the case on the right cord and arytaenoid joint, and on the glottic surface of the epiglottis.

Mr. BARWELL thought it tubercular rather than syphilitic, but rather of the nature of lupus, though one found it difficult sometimes to draw the line between the two. This case seemed to be a border-line one; the scarring on the pharynx could well be caused by lupus. The mouse-eaten appearance, mentioned by Dr. Smurthwaite, favoured the diagnosis of lupus. He would, however, try mercurial inunction. He asked that the subsequent progress might be reported.

Dr. GRANT, in reply, said he could not see any great objection to trying the effect of mercurial inunctions, watching her carefully during the treatment. If she were not given the chance that afforded, one might be making a mistake.

A CASE OF EXTREME WEAKNESS OF VOICE IN A MALE PATIENT,
AGED FORTY-ONE, OF FOURTEEN MONTHS' DURATION, APPARENTLY
AS THE RESULT OF A CHILL.

Shown by Dr. DUNDAS GRANT. The hoarseness first came on fourteen months ago, while the patient was acting in very wet weather, and, with very slight fluctuations, it has remained ever since. He was first seen by Dr. Dundas Grant, between three and four months ago; his voice was extremely gruff, and the swelling of the vocal cord was practically identical with what it is just now. There is a slight convexity towards the middle line, but then it was much more overhung by the right ventricular band, a portion of which was removed and found to consist of inflamed tissue. Appearances at first were suggestive of a tuberculous condition, but there is absolutely no physical sign of such disease in the chest, and the sputum has been several times examined, with negative result. Iodide of potassium was given in doses of ten and fifteen grains, three times a day, without any appreciable result, and no history of primary infection is obtainable. The patient went through great exertion, both as a soldier during the war and as a teacher of elocution, before the hoarseness commenced. At present the question is whether it is justifiable to remove a portion of the thickening of the vocal cord for microscopical examination, on the understanding that thyrotomy is to be sanctioned if the results of the examination render it advisable. Galvano-caustic puncture was made on the right cord without any effect, and a small nodule on the edge of the left one was also cauterised, but the voice became still weaker, as if the nodule which was destroyed had taken part in the production of sound.

Dr. JOBSON HORNE asked whether anything in the way of treatment had been done to the left half of the larynx.

Dr. GRANT replied that there was a little inflammatory projection on the surface of the left vocal cord, which he touched with the galvano-cautery. That shrivelled it up. That was ten days ago. The left cord was just as red then, so he thought it was not traumatic.

Dr. STCLAIR THOMSON said he was more impressed with the opposite side of the larynx, where there was an infiltration of the ventricular band; it was so thickened that it concealed the greater part of the vocal cord. Part of it might have been due to surgical treatment, but it had a rough edge, with small, white points. If it was formerly as red as Dr. Grant said, it was probably a very slow-moving tuberculosis. The right cord was succulent, but that might be due to the great amount of work it had had to do.

Dr. JOBSON HORNE thought it was premature to express an opinion

on that larynx at present. If Dr. Grant would show the case again at the next meeting, when the larynx had completely recovered from the local treatment, there would be a better opportunity of judging. He understood the patient was a professor of "voice-production."

Dr. GRANT, in reply, said he had never been able to dismiss from his mind the idea that it was tuberculous, and that was his opinion still. The patient was combatting tuberculosis most thoroughly, by eating largely and living in the open air, and was thus removing one of the diagnostic guides. He hoped members would keep the appearance in mind, and he would bring the patient again. He thought the idea of malignancy could be dismissed, and there was no occasion to remove a bit of the cord for examination.

A CASE OF LYMPHO-SARCOMA OF THE BASE OF THE TONGUE AND EPIGLOTTIS, PREVIOUSLY EXHIBITED; REMOVAL BY LATERAL PHARYNGOTOMY AFTER LIGATION OF ARTERIES; RECURRENCE OF LEFT PORTION.

Shown by Dr. DUNDAS GRANT. The case was shown at the November meeting, on which occasion Mr. Butlin advised that an attempt should be made to remove the growth by a lateral pharyngotomy, the branches of the external carotid being ligatured a few days before. On November 9 the exhibitor ligated the external carotid on the left side, and the lingual and facial arteries on the right. The result, so far as haemorrhage was concerned, quite confirmed what Mr. Butlin had said, and on the 12th the pharynx was opened on the right side, the hypoglossal nerve being retracted upwards and the disease removed, as was thought, completely, with hardly any haemorrhage. Two secondary haemorrhages occurred on the 17th and 19th, which caused some anxiety, but a rectal injection of gelatine was administered at the time of the second one, and no further haemorrhage took place. On the left half of the site of the growth a recurrence has taken place. Arsenic has been given in increasing doses, and two interstitial injections have been made of 5 minims of a 1 in 15 emulsion of papayin. These injections have caused no reaction, but the result remains to be seen.

Dr. GRANT said that since the recurrence he had given two injections of papayin into the substance of the growth.

Mr. ROBINSON asked which vessels Dr. Grant had ligatured.

Dr. GRANT replied that he ligatured the external carotid on the left side and the lingual and facial on the right side. The patient was now taking arsenic.

CASE OF ULCERATION OF THE RIGHT TONSIL IN A MAN, AGED THIRTY-TWO.

Shown by Mr. CHARLES A. PARKER. The patient was first seen three weeks ago, when he complained of pain and discomfort of three weeks' standing. There was then an ulcer on the upper part of the right tonsil, rather larger than a sixpenny bit, and covered with a dirty grey slough. The whole tonsil was enlarged and somewhat hard. One or two slightly enlarged glands could be felt in the neck. Since then the ulcer had greatly increased in size, both superficially and deeply, and there had been great loss of tissue ; moreover, the glands had become greatly enlarged, tender, or matted together. The question raised was that of the diagnosis ; was it syphilitic ? and, if so, was it a primary chancre or tertiary ulceration ? Mr. Parker had at first thought it was a primary syphilitic lesion, and had put the patient on hydrarg. c cret., but in spite of this the condition had become so much worse, and there was so much loss of tissue that he now doubted the diagnosis.

The PRESIDENT said he gathered that the patient had not had much treatment ; he had had mercury for a fortnight. He thought it was probably tertiary ulceration of the tonsil, and one could not say it had resisted treatment unless iodide of potassium had been given. There was much adenitis, but the septic condition of the tonsil would explain this.

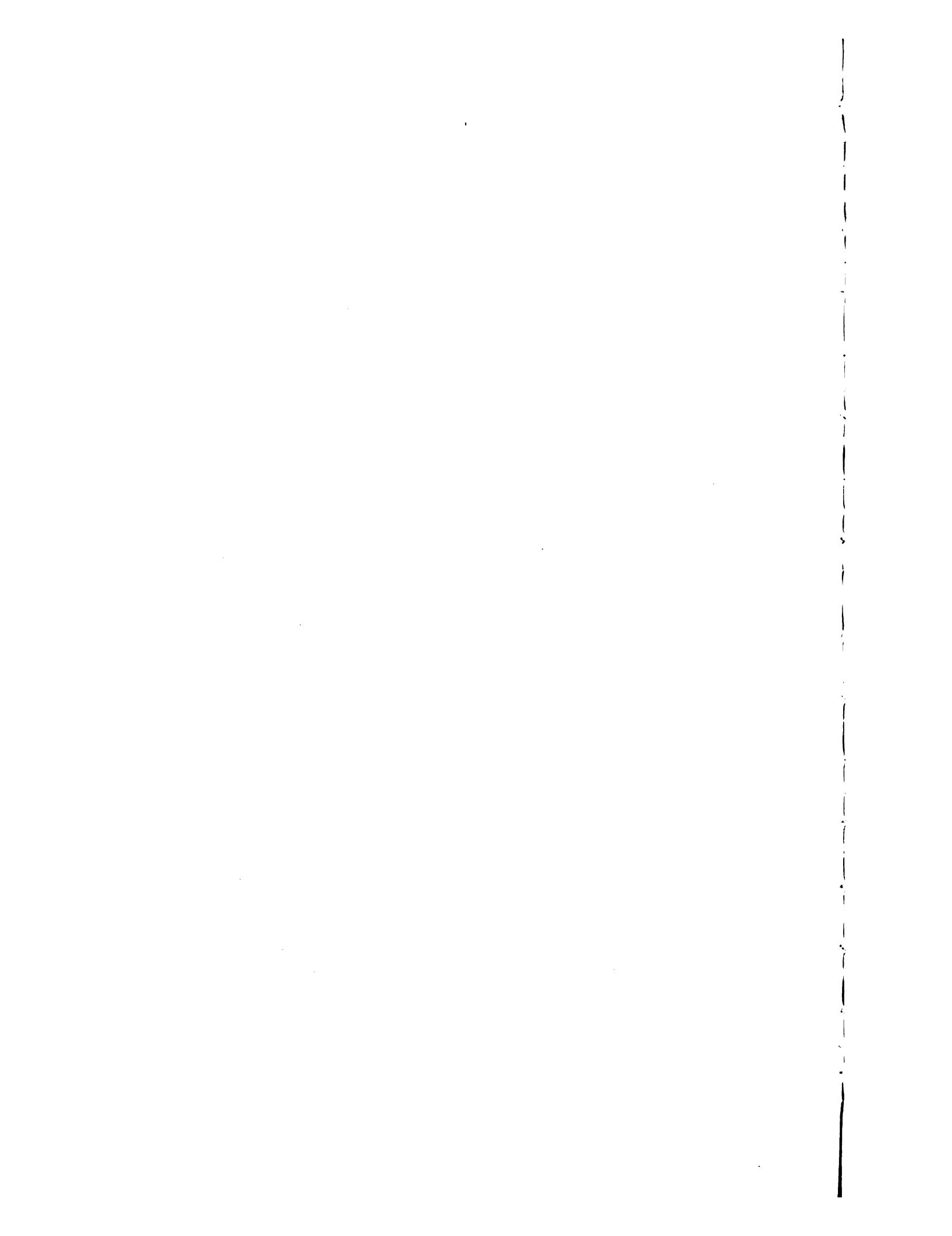
Mr. ROBINSON supported the President's suggestion as to treatment ; he thought it was tertiary syphilis, *plus* sepsis.

Mr. PARKER, in reply, said he had not put the patient on iodides, because when he first saw him the evidence was in favour of a primary sore, and therefore mercury was prescribed. He would now give large doses of iodide of potassium, combined with mercurial inunctions.

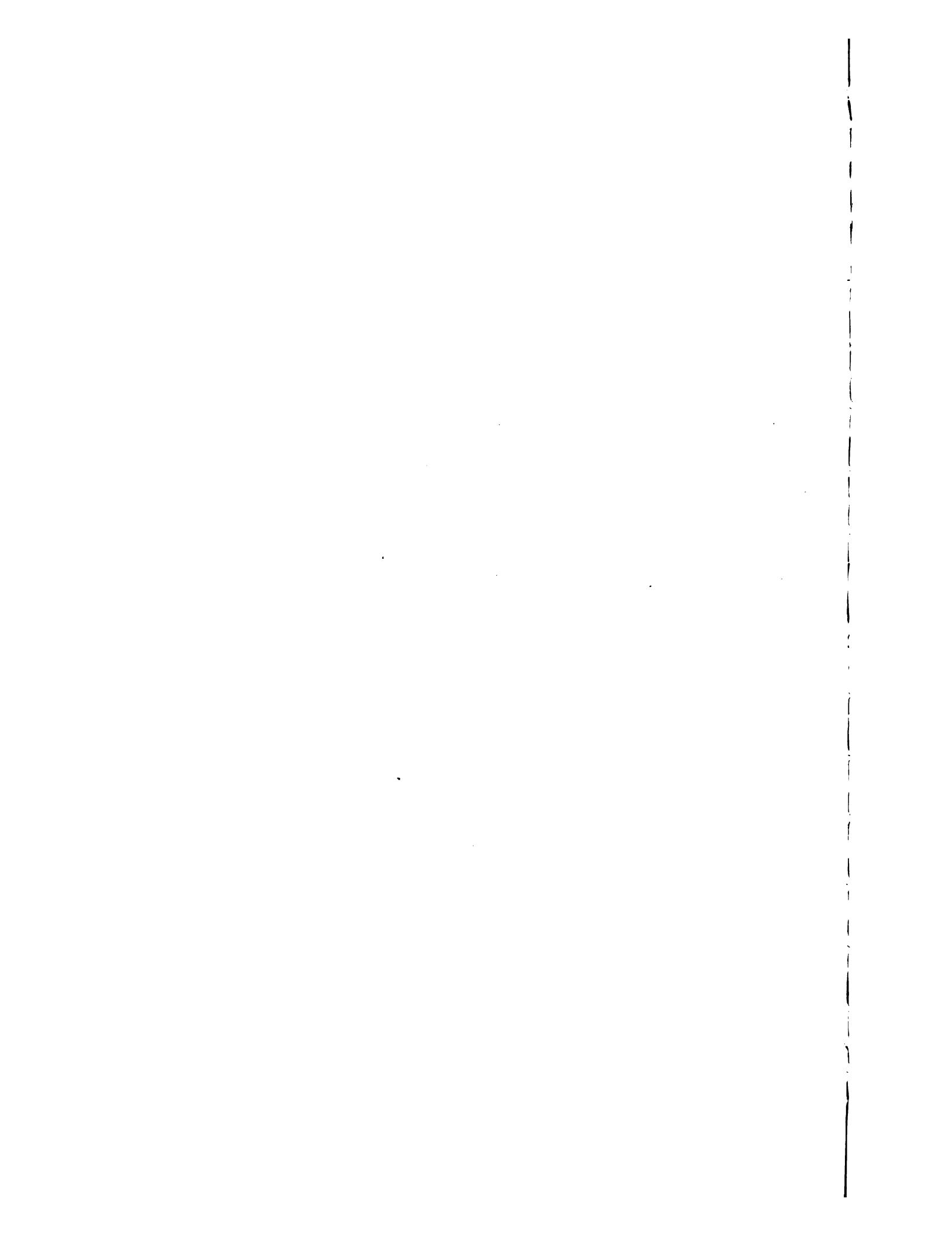
A CASE OF EPITHELIOMA OF THE TONSIL.

Shown by Mr. HAROLD BARWELL. The patient was a man, aged fifty-nine, with a history of syphilis thirty years ago. He had noticed something in the throat for six months. There was no pain and no palpable enlargement of glands. The growth was hard and involved the left tonsil ; it did not appear to go deeply, but had spread rather extensively on the surface on to the palate and anterior pillar. The opinions of members were requested as to the advisability of operation.

Mr. ROBINSON said it was, no doubt, epithelioma, and he advised Mr. Barwell to operate on it. The whole of it could now be got away ; there were apparently no enlarged glands in the neck. Still, the neck should be opened, and any small glands taken away.







PROCEEDINGS OF THE LARYNGOLOGICAL SOCIETY OF LONDON.

One Hundred and twelfth Ordinary Meeting, March 8, 1907.

J. B. BALL, M.D., *President, in the Chair.*

HENRY J. DAVIS, M.B., }
W. JOBSON HORNE, M.D., } Hon. Secretaries.

Present—45 members and 2 visitors.

The minutes of the previous meeting were read and confirmed.

The ballot was taken for

ALEXANDER R. TWEEDIE, F.R.C.S.,

who was elected an ordinary member of the Society.

The following communications were made:

MICROSCOPICAL SECTIONS OF NASAL POLYPI EXHIBITING PECULIAR SPIRAL AND KNOTTED THREADS OF (?) MUCUS IN THE SUBSTANCE OF THE GLANDULAR DILATATIONS.

Shown by Dr. HUGO LÖWY (Carlsbad) to illustrate a condition which, so far as he knew, had not been previously demonstrated. In the cysts and dilatations of the glandular structure scattered over the preparation were to be found, in the midst of the mucus and cells, threads of a peculiar twisted and knotted shape. These were partly spiral, and it had been ascertained that they consisted mostly of mucus, so as to be suggestive of the spirals in the bronchial mucus of asthma. Dr. Löwy stated that the sections had been fully described in his contribution to the *Schroetter-festschrift*,¹ and that he therefore need not take up time by entering into details. He showed the sections in order that the members might form their own opinions. Dr. Löwy stated that some years ago after making this pathological observation he entered upon

¹ *Zeitschrift für Klinische Medizin*, Bd. lxii.

a systematic research of nasal polypi which were found to contain cysts, and, after a long and laborious search, he was successful in finding an analogous condition in another case. An example from both cases was placed under the microscope. By the side of the specimens was placed a sketch of the part exhibiting the threads. Dr. Löwy regarded them as mucus worked up into thread-like structures by movement in the glandular tubes, brought about by variations of pressure on the polypi during respiration, similar to the formation of asthma spirals, but any other explanation might be offered without altering the value and the morphological interest of the observation.

Dr. H. PEGLER said the Society was much indebted to Dr. Löwy for bringing up these specimens. There were no sections of polypi in the Society's collection with which he could compare them, nor could he throw any light on the condition, but he agreed that these spirals were a peculiar form of coagulated mucus; and the surrounding conditions deserved investigation, particularly the dilated ducts that were so characteristic of these sections.

Dr. Löwy, in reply, said that he, like those to whom he had shown the specimen, was unable to offer any further explanation. It was difficult to say why only that part of the mucus which formed the threads had taken the haematoxylin stain; the threads were not distinctly separated from the surrounding mucus, but connected with it with irradiant lines of transition, and possibly might have acquired some chemical or physical property which enabled them to take the stain in the course of their formation. The mucus immediately surrounding the threads sometimes presented a more homogeneous appearance, like a mantle, different from the more distant mucus, containing more cells. The formation he had described and the analogy he had pointed out seemed not to be without interest in general medicine.

A CASE OF FISSURES ON THE TONGUE.

Shown by Dr. H. J. DAVIS. The patient, a man, aged twenty-two, presented oblique symmetrical fissures on the dorsum of the tongue. The possibility of the condition being due to lymphangioma or congenital causes was suggested.

The PRESIDENT said he rather doubted whether the condition was lymphangioma.

Dr. DE HAVILLAND HALL said he had seen similar fissures in the tongues of chronic dyspeptics, and had looked upon the condition as the outcome of the dyspepsia. He had had no idea that they might be regarded as congenital.

Dr. F. W. BENNETT said he had known cases with very marked fissures without any dyspepsia, and in one certainly the fissures had lasted all through life. He thought the present case was more likely to be congenital.

Dr. DAVIS, in reply, said the patient did not come to the hospital

complaining of his tongue, but because of trouble in his nose. Cases of dyspeptic tongue usually had some symptoms referable to the tongue; discomfort there at least was complained of. This patient said he had always had the fissures since he could remember. He (Dr. Davis) believed the lateral parts of the tongue were said to be developed from the muscle plates of the visceral arches. There was also a malformation in the patient's soft palate which supported the view that the case was congenital. One of his surgical colleagues regarded it as lymphangioma.

A CASE OF PAPILLOMATA OF THE LARYNX (SHOWN NOVEMBER, 1906).

Shown by Dr. DAVIS. The patient was a girl, aged nineteen. When brought before the Society last November, the larynx was crowded with papillomata; these were removed by forceps and snare. The vocal cords were now red, and aphonia persisted. Suggestions as to further treatment to improve the voice were invited.

The PRESIDENT thought the voice was now very good and that the patient would not require treatment if the papillomata did not recur. She ought to be satisfied with the voice she now had.

Mr. F. J. STEWARD asked whether any special treatment had been used in the case with a view of preventing recurrence of the condition after removal.

Dr. DE HAVILLAND HALL was inclined to advise leaving the case alone now. She seemed satisfied with her voice, which appeared to be in a fairly healthy condition, and he would not irritate the cords by any local treatment.

Dr. DAVIS, in reply, said when first shown she had a mass of papillomata, which it was suggested should be removed by thyrotomy. However, he tried several times with forceps and the snare and got it all away. Some attached to the cords were removed with Dr. Dundas Grant's forceps. She was now able to breathe quite well, but her voice had not recovered, though it was very fair that day. The only local treatment he had applied was lactic acid (40 per cent.) by means of a miniature laryngeal spray used by the patient. She still had chronic laryngitis, which did not seem to have recovered as rapidly as it might.

A CASE OF TUBERCULOSIS OF THE LARYNX IN A WOMAN, AGED THIRTY-THREE.

Shown by Mr. CHARLES PARKER. This patient was first seen seven years ago with tuberculosis of the larynx and slight physical signs at the right apex, which were first noticed immediately after the birth of her fifth child. She was shown to the Society in February, 1905, as an example of a woman who had commenced pulmonary and laryngeal tuberculosis during pregnancy and had survived four subsequent pregnancies. Since 1905 she had had one further pregnancy, ending in a miscarriage. In all she had had ten con-

ceptions, including four miscarriages, and of the six children born alive three had died of tuberculous meningitis. This history suggested tuberculosis in the mother. Two years ago, when the case was shown, several members of the Society maintained that the appearance, at that date, suggested a chronic inflammatory thickening.

Mr. Parker had lost sight of the patient until last Christmas, when she was admitted into hospital with urgent dyspnœa. Then both the supra-glottic and subglottic regions were filled with what appeared to be chronic inflammatory overgrowth. With rest in bed and mercurial inunctions the swelling had so far subsided as to put the patient out of danger of suffocation, but there were still present large masses of this inflammatory overgrowth. Mr. Parker asked for an explanation of this transition from what was almost without doubt originally a tuberculous infiltration to the present condition of chronic hyperplasia. He would also like suggestions as to the treatment, though he felt inclined to leave the local condition alone.

ABSCESS OF THE RIGHT FRONTAL LOBE, SECONDARY TO CHRONIC BILATERAL FRONTAL AND ETHMOIDAL SINUS SUPPURATION.

Shown by Dr. W. MILLIGAN. The patient, a girl, aged twenty, was sent to me on account of persistent purulent discharge from both nasal passages and intermittent frontal headache of several years' duration. Examination showed that both frontal sinuses and both ethmoidal labyrinthines were the site of suppurative disease. After a short preliminary antiseptic treatment both frontal sinuses were operated upon according to the Killian method, at the same time both ethmoidal labyrinthines being opened up and drained. The operation took place upon October 11, 1906. The patient made excellent progress up to November 6, when she had a severe attack of septic tonsillitis which lasted for a few days. From November 13 to November 27 she appeared to be in good health, complaining only of a dull feeling in the head. She was able to assist in light ward work and appeared cheerful. The temperature was normal, the pulse regular, and there was no tendency to sickness or vertigo. There was still slight discharge from the right nasal passage of a distinctly foetid character. The left frontal sinus had entirely healed up and there was no discharge in the left nasal passage. Upon November 27 her temperature suddenly rose to 101·8° F., and she complained of intense head-

ache. Upon the morning of the 28th the temperature was 97·4° F. A careful examination was made under an anæsthetic, and search made for the source of pus from the right nasal passage, without, however, any definite result. By December 8 her temperature was again normal, and remained so until December 20. Upon the morning of December 20 she had a severe shiver, and her temperature rose to 101° F., while her pulse was 92. Her headache became very severe and distinct double optic neuritis was found. A lumbar puncture made the following day showed an opalescent cerebro-spinal fluid. For the next few days the temperature varied from 100° F. to 103° F., and the pulse from 80 to 108. The patient rapidly sank into a comatose condition and died upon the morning of December 26.

A *post-mortem* examination made twenty hours after death revealed diffuse suppurative pia-arachnitis over the base of the brain, especially over the under surface and lateral portions of the right frontal lobe. Upon the under surface of the right frontal lobe a small abscess cavity was found containing very foetid pus. This abscess cavity communicated with the general pia-arachnoid cavity and by a minute fistulous tract with the posterior ethmoidal cells. The discharge, which persisted in the right nasal passage after the first operation, was doubtless oozing gradually from the frontal lobe abscess.

Dr. STCLAIR THOMSON congratulated Dr. Milligan on giving the Society the lesson to be learned from the case. He had had a similar one, and as it had not been published he brought the brain to show. A transverse section across the frontal lobe showed the abscess in the centre of the frontal lobe, on the left side. There was no direct macroscopical connection with the frontal sinus; the pus had recently burst through the left side, and trickled down into the anterior fossa. But it was evidently a latent abscess in the frontal lobe. The patient was up and about seven days after he did a Killian operation on the left side. She was so relieved that she was most anxious to have the other side done. Her headache set in 16 to 18 days after the operation, and death occurred four weeks after operation. Dr. Milligan's case, like his own, showed the risks run by surgeons in serious operations on the sinuses, because, except that she fainted in the ward and was considered to have funny manners—being regarded as somewhat hysterical—there was no evidence that she had the abscess. The surgeon was apt to blame himself, and certainly the friends were apt to blame him, believing the fatal result to be due to the traumatism, whereas in Dr. Milligan's case the time which had elapsed—longer even than in his own—was sufficient to show that it was a latent abscess, although the traumatism might have precipitated the fatal termination.

Mr. HERBERT TILLEY said that one point which both the cases illustrated was that which had a bearing upon treatment in those cases. Affections of the meninges and frontal lobes did not occur as frequently

from the frontal sinus as from the ethmoidal cells. In the literature of the subject it would be found that in the vast majority of cases the fact seemed to be established. Therefore in the operation it was very important to thoroughly clear the ethmoid region. For thirteen years he had been looking for a case of abscess in the frontal lobe due to pure frontal sinus suppuration, but he did not think he had yet seen one. He thought he had experienced one a month ago when he saw a man in a very depressed condition, which was ascribed to his mother having died very suddenly a week before. Since that event he had not spoken to anyone. A small operation had been performed on his ethmoidal region a few weeks previously, and there were some indications that suppuration was still going on there. The case was difficult of diagnosis because it was impossible to separate the effect of the disease from his domestic trouble. Three days afterwards the man became comatose and died. *Post-mortem.*—A large abscess was found in the frontal lobe, but it was proved that it came from the ethmoidal region. If ethmoid suppuration was efficiently dealt with the frontal sinus disease would rarely cause fatal complications.

Dr. SCANES SPICER desired to repeat what he had often said before—how desirable it was in his opinion to thoroughly attack the middle turbinated and break down and drain the ethmoidal cells, especially the anterior group, before operating on the frontal sinus from the outside. He asked whether that was done in Dr. Milligan's and Dr. StClair Thomson's cases; did they resect the middle turbinated body and break down the anterior ethmoidal cells before tackling the frontal sinus from the outside? He must have had great good luck in his frontal sinus cases, as he had had no experience of any of the serious extensions referred to by other workers—at least, it was good luck unless, indeed, the avoidance of such extensions were the result of the antecedent ethmoidal drainage. If what he recommended were done, he believed, moreover, that Killian's, as well as other external, operations would be less needed.

Dr. PERMEWAN said he thought Dr. Scanes Spicer's luck consisted rather in not having found a latent frontal abscess, than in the method which he adopted. Dr. Spicer seemed to take the view that Dr. Milligan and Dr. StClair Thomson produced the abscess in their cases; whereas the notes made it clear that the abscess in each case was there before. All had probably seen cases of abscess thought to be due to frontal sinus cases which might perhaps be attributable to ethmoid cell-disease. Another lesson furnished by the cases seemed to be the need of trying to discover whether there was any intracranial suppuration before attempting operation on the frontal sinus. It was not easy to discover abscess in the frontal lobe, but it was well to bear it in mind.

Dr. WATSON WILLIAMS said he did not think many would be inclined to subscribe to the suggestion of Dr. Scanes Spicer that in such cases where it had been decided that an external operation on the frontal sinus was necessary the suppurating ethmoidal cell should be cleared away before doing the major operation on the frontal sinus. He thought one should avoid attempting to deal with suppurating ethmoidal cells, except the anterior and lower ones, until the frontal sinus was opened, when the cells could be attacked from the front, and when it was so much safer to be thorough in their removal. And, *à propos* of his own case that day, it could now be done with comparative safety.

Mr. WESTMACOTT agreed with Dr. Scanes Spicer that in the majority of cases one could deal with the ethmoidal labyrinth, especially the anterior division, from the interior of the nose. He had come across two

chronic cases only in which he had been obliged to do an external operation, and that experience was borne out by Hajek, of Vienna, who said that the external operation was required for only a very few cases. It was principally the anterior ethmoidal labyrinth which was affected with the frontal sinus, and that which mostly caused the intracranial abscess, subdural, or in brain matter, infection occurring either through a perforation of the posterior and upper wall of the frontal cavity or the cribriform plate of the ethmoid.

Mr. E. B. WAGGETT desired to speak in the same sense as Mr. Westmacott. Not only the anterior, but the posterior ethmoidal cells were easy to attack by the nasal route. Frontal sinus operations were very delightful to do, but a good many of the cases were not quite dry after the operation. He thought the cases attacked by the nasal route had, as a general rule, as good a result so far as clinical symptoms were concerned as those done by external operation.

Dr. FITZGERALD POWELL said that he understood that in Dr. Thomson's case the abscess occurred eighteen days after the operation, and in Dr. Milligan's case six weeks after. This rather gave one the idea that possibly the infection might have occurred at the time of operation. There was some doubt as to whether frontal sinus suppuration was responsible for the causation of latent frontal abscess, some holding that it was due to infection from the ethmoid suppuration. In some cases of frontal sinus suppuration which he had operated on there had been an opening leading from the frontal sinus to the meninges. No frontal infection had taken place. He would not like to say that the present frontal abscess was due to infection nor to the operation from the facts before them, but, of course, no blame attached to the operator.

Dr. STCLAIR THOMSON regarded Dr. Tilley's remarks as an expression of opinion, but he did not see how it was proved that the ethmoidal cells were the cause, and not the frontal sinus. He had made, from literature, a collection of thirty or forty cases of spontaneous abscess in the frontal lobe, where there was no traumatism, and where it was shown that the frontal sinus was the source of the latent abscess in the frontal lobe. Hajek had said that from the ethmoid one got meningitis; from the sphenoid, meningitis and thrombosis of the cavernous sinus; and from the frontal sinus, frontal lobe abscess. If Dr. Tilley was speaking of traumatic abscesses he agreed with him; but it was shown by the spontaneous cases that the frontal sinus was the chief cause of latent abscess in the frontal lobe. As to the frontal operations being necessary, he would be glad to send anyone six cases from his clinique in which he had cleared out the ethmoid—he always did as Dr. Scanes Spicer had suggested—under chloroform as thoroughly as possible; but it was impossible to clear out the fronto-ethmoidal cells from the nose, and that was why Killian introduced his operation. Those cases which he had done had been relieved of their obstruction and polypi, and there was very little left, except the fronto-ethmoidal cells, and those cases still had a discharge. He would be glad to hand them over to anybody. They were hospital cases, and were begging for relief.

Dr. MILLIGAN, in reply, said he thought there was no question that his case was a latent abscess. He did not take the credit of having produced it. As a fresh specimen it was quite obvious that it was a chronic abscess-cavity in the frontal lobe, and the history of the case lent support to that view. He admitted he did not diagnose the abscess, but if he had done so he did not know what operation would have been successful.

The importance of the ethmoidal cells as a causative factor in frontal lobe abscess was uncertain; only few recorded cases had been brought forward. He had seen one other case in which the cause of the abscess was the frontal sinus, because there was a direct communication between the abscess and the frontal lobe. With regard to clearing out the middle turbinate region first, sometimes he did that, but he had not done so in this case. He did not see any particular advantage in it when one had to do a fairly extensive operation afterwards. All could just as well be done at one sitting. With regard to Mr. Westmacott's remark about such operations being unnecessary, that gentleman's experience seemed to have been most fortunate. He had many times tried to deal with such cases through the nose, but had failed to cure them. He thought one could guarantee a cure with a properly-conducted Killian, but there seemed to be some diversity of opinion, as shown by practice, as to what a Killian was. There were many cases in which operation was urgently called for; they were almost entirely in hospital patients, who were unable to do their work, having severe frontal headache and an uncomfortable purulent discharge from the nose, which he regarded as legitimate indications for operation. It was rare to have a bad result.

A CASE OF EXOSTOSIS OF THE FRONTAL SINUS.

Shown by Dr. W. MILLIGAN. The patient, a male, aged sixty, consulted me in 1897, complaining of bilateral nasal obstruction, nasal discharge, and intermittent frontal headache. Examination showed the presence of nasal polypi. Under an anaesthetic a radical operation was performed, the growths being removed, and the middle turbinated body, together with the anterior group of ethmoidal cells, being scraped away with a Volkmann's spoon.

For seven years no inconvenience of any sort was complained of. In 1904, however, the patient had again slight nasal obstruction, and was treated by a medical friend, some small oedematous buds of granulation tissue being removed. A small exostosis was noticed at this time.

In December, 1906, he again came under my care, and was found to have a large, bony growth springing apparently from the left frontal sinus, and encroaching upon the left nasal passage and left orbital cavity. The left eye was displaced outwards and downwards, and the conjunctiva was injected. Vision was perfectly normal. The growth was very hard, and appeared to be firmly attached to its point of origin. An X-ray photograph was taken.

As the patient was aged—now seventy—and as there was no real discomfort complained of, the advice given was to wait for two months so as to watch the progress of events. At the beginning of February the patient again presented himself for examination. Pain was complained of at the back of the left eye, the conjunctiva

was deeply congested, and the eyeball was displaced still further downwards and outwards. Operation was now advised. The patient was accordingly put under an anaesthetic and a supra-orbital incision made, as if for opening the frontal sinus. The bony arch of the orbit was chipped away in the neighbourhood of the exostosis, and the frontal sinus opened. The growth was found to spring from the floor of the sinus, and to have a fairly broad attachment. Within the frontal sinus there was a considerable amount of muco-purulent secretion, and also an oedematous mucous polypus. By somewhat forcible traction and leverage the growth was removed. The sinus was now cleansed and packed, the incision being almost entirely sewn up with the exception of its extreme lower limit. Progress since the operation has been quite uneventful, and the eyeball now practically occupies its normal position.

A CASE OF VERY EXTENSIVE PAPILLOMATA OF LARYNX (SPECIMEN EXHIBITED).

Shown by Mr. BETHAM ROBINSON. The specimen was obtained from a little girl, aged five, who was under treatment in St. Thomas's Hospital at different periods between March 12, 1904, and January 2, 1907, the date on which she died. On admission there was the usual history of difficult breathing and only a whispering voice. Examination was impossible without an anaesthetic, and on March 19, while this was being attempted, she suddenly stopped breathing, and tracheotomy had to be done. It could then be made out that there were very numerous papillomata all over the upper aperture of the larynx and also on the vocal cords. On March 23 many growths were removed intralaryngeally, and this was repeated on April 13. After this the tube was removed. The wound healed by the 21st, and she was sent out. She had to be re-admitted on May 14 for severe dyspnoea, and had to be intubated. Further growths were removed intralaryngeally, and this was repeated on July 9 and 23. On August 27, while away on my holiday, she had become so obstructed that the tracheotomy wound was re-opened and a tube inserted. On September 15 I did thyrotomy, removing all the evident growths with scissors and cauterising their bases. The tracheotomy tube was retained, but removed on the 20th, and the wound was healed by the 30th.

The breathing remained now free, and there was improvement

in the voice during the next three months. At the beginning of January there was more obstruction and fresh growths seen, so on the 6th they were again removed intra-laryngeally, which had to be repeated on February 11. In my absence on February 27 she suddenly became moribund, and laryngotomy was done. After this I again removed growths with the forceps, and was able to dispense with the tube. From then to the end of May she did well, and was out of hospital, but at the beginning of June she was admitted with broncho-pneumonia. Obstruction was so marked on the 16th that she was intubated, and the lungs having cleared more growths were removed with forceps on July 5. There was another period of respite till another sitting was necessary on October 31.

The rest of the history may be summed up by saying that there were varying periods of comfort followed by increasing difficulty of breathing, as a rule, demanding instant relief. For this an intubation tube was introduced, and I followed this by clearing the growths away as thoroughly as possible with forceps. During 1906 there were nine removals with forceps, the last one being on November 14. After this date she had seemed very much better, but at the end of the year the breathing was again becoming bad. She died quite suddenly on January 2 before any relief could be given.

All the endolaryngeal operations (nineteen in all) were done in the sitting position, under chloroform, with Mackenzie's forceps, both those cutting antero-posteriorly and laterally being used. Powdered alum and a weak formaline spray were used from time to time without apparently diminishing the growths.

The specimen shown is a very interesting one, demonstrating how wide-spread the growths are distributed, and how hopeless was the task of completely eradicating the disease. They are situated not only all round the upper orifice of the larynx, and in the larynx in profusion, but they spread downwards over the pharyngeal surface of the cricoid to the oesophagus; there are scattered patches also on the posterior part of the tongue and on the tonsils.

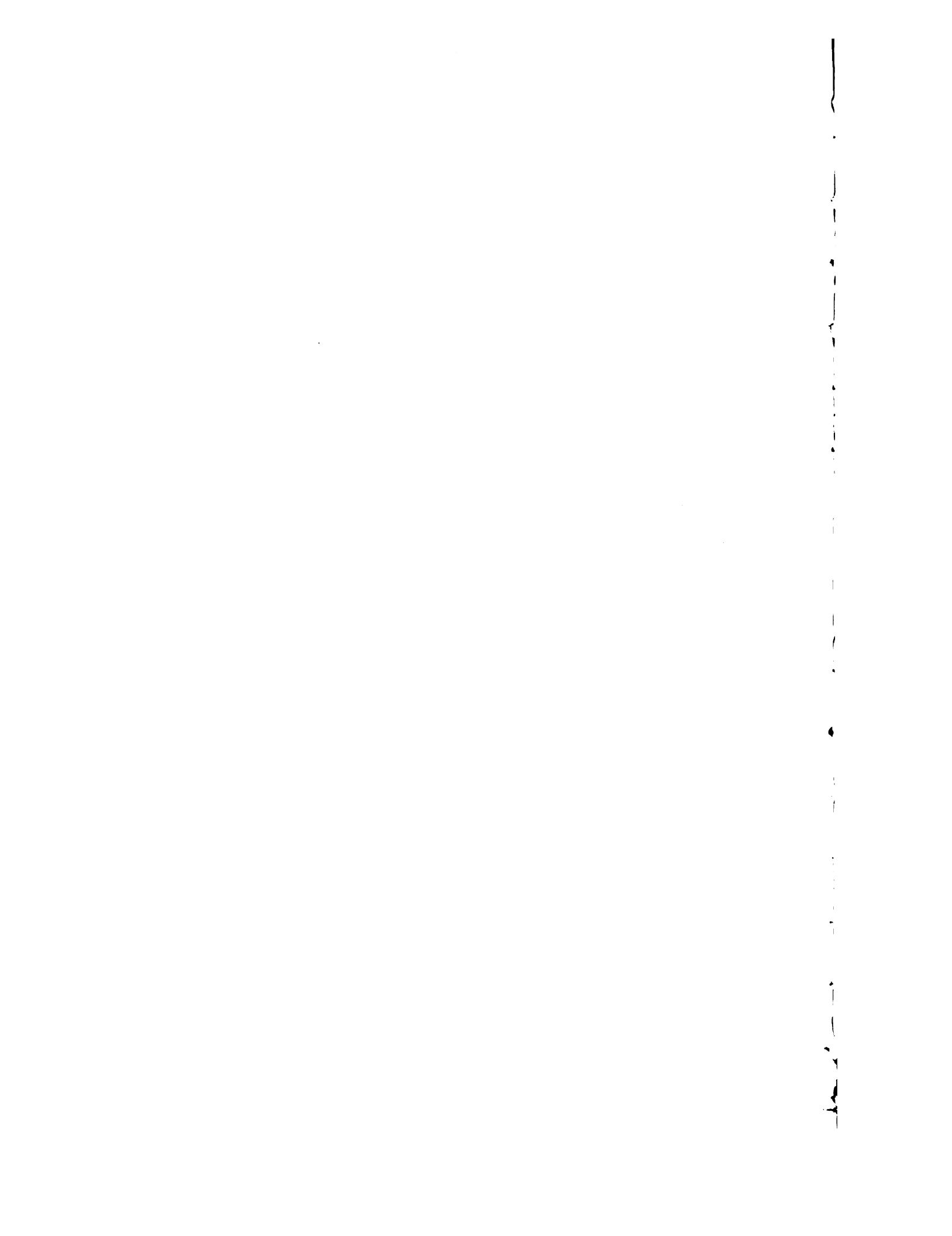
At the autopsy there was some collapse of lungs and some suspicious patches of caseating tubercle. The bronchial glands were definitely tuberculous, and at the roots of the lungs there were tuberculous nodules spreading inwards along the septa. There was also a doubtful tuberculous deposit in the spleen. It is an interesting speculation whether the papillomatous growths



Photograph of the specimen showing the base of the tongue and the upper orifice of the larynx displayed from behind by opening the pharynx and œsophagus. A piece of glass rod is passed into the orifice of the larynx. The papillomata are seen to be very freely distributed over the epiglottis, the ary-epiglottic folds, and the back of the larynx ; they also pass outwards into the pyriform sinuses and downwards over the back of the cricoid into the œsophagus. There is to be seen a polypus in the œsophagus.

To ILLUSTRATE MR. BETHAM ROBINSON'S CASE OF PAPILLOMATA OF THE LARYNX.

Communicated to the Laryngological Society of London March 8, 1907.



themselves were of tubercular origin ; those examined gave no evidence, however, of such being their nature.

The **PRESIDENT** said he thought the excellent photograph of the case which had been handed round might very well be reproduced in the *Transactions*.

RHINO-SCLEROMA OF THE NASO-PHARYNX IN A POLISH GIRL, AGED NINETEEN.

Shown by Dr. STCLAIR THOMSON. It is difficult to give a history of this case as the patient only speaks Polish, and communication has only been possible through one of her compatriots, who speaks very little German. It seems that for six or more years she has had increasing difficulty in nasal respiration. Some four years ago an operation was performed in Dr. Heryng's clinic in Warsaw, with some relief. But latterly the nasal obstruction has been increasing.

The patient complains of nasal obstruction and difficulty in clearing the nostrils of mucus. There is complete anosmia, but no interference with hearing.

The nasal chambers show a pale hypertrophy of the turbinals, with much stringy mucus on the floor ; nothing abnormal is seen in the pharynx or larynx. With the post-nasal mirror a red, fleshy diaphragm is seen extending from the base of the soft palate upwards and backwards to the junction with the roof, and posterior wall of the cavum pharyngeum. There is an oval diaphragm in the centre of this fleshy membrane through which can be seen a small part of the posterior edge of the septum. This membrane bleeds when touched with a probe, and to the finger it is of cartilage-like hardness.

Although we have not yet obtained a portion of the growth for histological and bacteriological examination, this would appear to be a case of true rhinoscleroma. Apparently most cases have some manifestations in the nose, but the disease may begin primarily in the naso-pharynx. The first case published in this country was that of Payne and Semon in the "Transactions of the Pathological Society," vol. xxxvi, 1885. The only other case shown before our Society is that of Dr. Dundas Grant, published in the *Proceedings*, vol. vii, April 7, 1900.

I should be very pleased to have the opinion of members, especially in regard to treatment.

Mr. C. A. PARKER asked what Dr. Thomson founded his diagnosis

upon. He had only seen one case, and that was not in the post-nasal space. His idea was that rhinoscleroma was a red, smooth-surfaced infiltration, whereas in the present case the swelling looked rough and uneven, more like a growth filling up the naso-pharynx.

Dr. STCLAIR THOMSON, in reply, said it must be remembered that the case had been operated upon, and there was a distinct hole in the middle of it, through which one could see the posterior edge of the septum. He founded his diagnosis on the appearance of the diaphragm and the extreme cartilaginous feel of it. There was a history that it had recurred after operation when it was partly relieved. He overlooked the case the first time it came to his clinique, but the cartilaginous feel revealed the condition.

ENDO-LARYNGEAL GROWTH IN A MAN, AGED TWENTY-NINE.

Shown by Dr. STCLAIR THOMSON. This patient denies specific disease, and has never been ill before. He has been hoarse for ten months, with some occasional slight pain on the right side of his larynx, running up to the ear. He states he had not lost flesh, but has gained till lately. The patient was under the care of Mr. C. E. Bean, of Plymouth, who has watched the growth increasing, especially in its tendency to fungate, in spite of iodide of potassium up to 45 grs. a day and mercury. Chest examination is negative.

It will be seen that there is a fungating infiltration of all the right vocal cord, the anterior commissure, and part of the left vocal cord. The growth, in parts, has a necrotic, white look. There is a small gland to be felt on the right side of the larynx.

The points to be submitted are—(1) Is this a malignant growth in spite of the early age? (2) Should a part be removed for operation? and (3) Would thyrotomy afford any prospect of complete relief?

Recent loss of weight and strength, together with pallor of the mucous membranes, rather pointed to the diagnosis of tuberculosis.

Dr. PEMEWAN regarded the case as tubercular.

SO-CALLED PROLAPSE OF THE VENTRICLE OF MORGAGNI IN A WOMAN, AGED FIFTY.

Shown by Dr. STCLAIR THOMSON. The title of the case describes it.

INFILTRATION AND ULCERATION OF THE UVULA IN A MAN; TUBERCULAR.

Shown by Dr. STCLAIR THOMSON. Without the previous history of the case it would have been difficult to have diagnosed this con-

dition simply from appearance. The patient came to me some weeks ago complaining simply of sore throat. The uvula was then replaced by a large, irregular, firm, pale infiltration, with a sloughy ulcer running across the base of its attachment to the soft palate. There were no glands, no fever, and no general reaction. On the palatal side of the sloughy ulcer there was an irregular, half-inch margin of bright red hyperæmia. In the post-nasal space it was seen that the disease did not spread higher up than the uvula.

Although rapidly improving the condition well shows that one might have the suspicion that it was of specific origin. But the patient for over a year has been under treatment with a tuberculous ulcer on the left arm. The tubercular nature was proved by histological examination. This ulcer exposed the tendons, and was so deep and wide that no other remedy was suitable except tuberculin injections, which were given under the control of the opsonic index. It was some time after this ulcer had healed over that the pharyngeal condition developed. He has had no other treatment for the latter beyond peroxide gargle, and it is rapidly healing up under renewed tuberculin injections. The patient has no pulmonary or general symptoms.

I think his condition is distinctly tubercular, and although lupus is common enough in the pharynx it is rare to meet with what we clinically call tuberculosis of the pharynx except in the last stage of pulmonary phthisis. If we depended, however, on other than the simple appearance, I think it would be difficult to diagnose the present condition from that of a tertiary ulcerating infiltration.

Dr. WATSON WILLIAMS said he was struck with the remarkable resemblance between the case and one which was under his own care for some time, and which he demonstrated as a tuberculous lesion. She went to a sanatorium and was restored, but in spite of various curettements and other treatments the throat lesion did not clear up. She was a young woman above reproach, and unmarried. Yet when given iodide of potassium the whole thing cleared up. Unless Dr. StClair Thomson had given iodide of potassium he strongly suggested it, as it was not a typical tuberculous ulcer, and some features of it looked like those of syphilis.

Mr. CRESSWELL BABER thought the lesion was syphilitic, and recommended that iodide of potassium should be pushed. A supposed tubercular affection of the pharynx often turned out to be syphilitic.

Dr. STCLAIR THOMSON, in reply, said the man had had no treatment, but was getting well under tuberculin injection.

A CASE OF LUPUS OF PALATE AND LARYNX TREATED WITH TUBERCULIN R.; IMPROVEMENT.

Shown by Dr. E. A. PETERS. F. M——, admitted to hospital November 21, 1906, for lupus of larynx, pharynx, enlarged submaxillary glands, and tuberculide of the left leg; she had been previously treated elsewhere with arsenic for three months, and had not improved.

Dr. Rees injected .0002 T.R. in the positive phase at intervals of fourteen and six days. This treatment was followed by the administration of arsenic, but this was withdrawn when slight sickness and pyrexia appeared.

February 13, 1907.—There was inspiratory and expiratory stridor, due to large, flabby excrescences in the larynx. The glands were smaller and the chest sound. The upper edge of the palatal area was quieter, and the tuberculide on the leg had healed over in the centre and at one edge.

At present the stridor has disappeared and cicatrisation is very marked. The tuberculide has healed over, and the patient is receiving arsenic.

Dr. MILLIGAN suggested the advisability of tracheotomy, so as to ensure laryngeal rest.

Dr. STCLAIR THOMSON said he thought the result was very poor, and he said that with sympathy, because he put several very promising cases of lupus, limited entirely to the air-passages, under tuberculin treatment controlled by the opsonic index. Not one of them had been made better by the treatment, but one or two were distinctly worse. In one patient, each time she had an injection fresh nodules of disease appeared. The cases had, however, done well on galvano-cautery puncture.

Dr. PETERS expressed his thanks to Dr. Milligan and Dr. StClair Thomson for their remarks, and said he would bring the case forward again for observation.

FUNCTIONAL PARESIS OF THE PALATE.

Shown by Dr. E. A. PETERS. T. M——, aged twenty-four, five months ago was attacked with laryngitis, when she noticed her voice change. At times her voice is quite normal. She now suffers with a choking sensation in the throat. There is some vaso-motor rhinitis of the nose, and the palate is slightly full.

On attempting to phonate all the palate moves slightly, but the "pits" are only brought into evidence on stimulating the palate with a probe or requiring her to take a deep breath.

If the palate is stimulated while she phonates her voice loses the accent. There has been no evidence of diphtheritic trouble.

Dr. PEGLER regarded this as an interesting example of simulated or functional nasal obstruction, and questioned if the term functional paresis of the palate described the condition fully enough. In addition to a tardy contraction with dimpling, on stroking with a probe, there was sometimes spontaneous contraction of the velum, and then the "rhinolalia clausa" was well marked. In the functional paresis commonly seen with true nasal obstruction there was no such contraction, and the speech defect was of the opposite kind (*r. aperta*). He had recently been consulted by a lady in whom the prevailing pose of the soft palate was one of contraction, and the rhinolalia so marked that she was constantly credited with suffering from a bad cold in the head. The most rational way of regarding this condition appeared to be as one of mal-co-ordination of the palatal muscles, with consequent interference with their normal action during speech. It was analogous to the disordered co-ordination of the laryngeal muscles in functional aphonia, as evidenced by the fact that the two conditions, palatal and laryngeal, are sometimes associated.

Dr. PETERS, in reply, said he regarded it as functional paresis, very much on the same lines as functional aphonia. He believed there were all grades of the condition. He had several cases under his care. The present case had more oedema of the palate than usual.

**TRACHEOTOMY FOR LARYNGEAL OBSTRUCTION, REMOVAL OF FIBROMA
BY SPLITTING CRICOID; UNRELIEVED; LATER THYROTOMY AND
REMOVAL OF ANOTHER FIBROMA.**

Shown by Dr. E. A. PETERS. G. P——, aged six. Admitted to hospital June 6, 1906, for difficulty of breathing, which came on quite suddenly, after the voice had failed six weeks. Under an anaesthetic a white swelling appeared in the larynx, and tracheotomy was performed on June 13. On July 8, the cricoid was divided, and a smooth, white fibroma, the size of a hazel-nut, was removed from the anterior end of the right cord. During the manipulation something seemed to slip between the cords, but as the lower edge of the cords were seen to be free, the cricoid was stitched up. On October 11, as obstruction still persisted, thyrotomy was performed, and another fibroma, the size of a hazelnut, adherent to the anterior end of the right cord was removed. The child has made a good recovery.

Dr. PETERS asked what the experience of members was in such cases. He learned that in children it was usual to split the cricoid, and remove the growths in that way, which was more desirable than doing thyrotomy. He did that in the present case, and it meant an additional operation, as he had to do thyrotomy eventually, and that was successful.

A CASE OF FRONTAL SINUS DISEASE, SHOWN ON JUNE 1, 1906;
KILLIAN'S OPERATION.

Shown by Dr. E. A. PETERS. A. W—, aged forty-six, last year presented an intractable sinus beneath right supra-orbital ridge. A probe failed to enter the right frontal sinus from the nose, but the left frontal sinus was patent and contained pus, which was also present in the right nostril. A radical cure for a suppurating left antrum had been previously carried out.

Dr. STCLAIR THOMSON suggested that a double Killian's operation should be performed, and the patient was now shown with an aluminium style *in situ* on the right side. There is no pus in the nose. There was no frontal sinus on the right side, but extensive fronto-ethmoidal and ethmoidal disease on both sides.

Mr. HERBERT TILLEY thought probably the sinus was possibly due to a septic ligature placed on one of the vessels while the operation was being performed. Dr. Law would remember a case in which they (the speaker and Dr. Law) had an absolutely identical condition. For many weeks a suppurating fistula baffled all attempts to close it, until a small stitch came away, and the wound healed in three days.

Dr. LOGAN TURNER agreed with Dr. Milligan that the term "Killian" was often used in a loose way. He would like to know if Dr. Peters had obtained proper access to the frontal process of the superior maxilla through an incision such as the patient showed, and whether he had really done a Killian, as the title of the operation suggested.

Dr. PETERS, in reply, said it practically was a Killian. He always opened the infundibulum and worked up from that. The incision was more extensive than it now appeared to have been. He got a very free opening there by retracting the parts. He left the bridge there, but the anterior and inferior walls of the frontal sinus were removed. The ethmoidal cells, which were full of pus, were scraped and nibbled away as far back as the sphenoidal sinus.

CASES OF CHRONIC FRONTAL SINUSITIS.

Shown by Mr. STUART Low. He said that he had brought forward more cases as they showed a minimum of deformity and a maximum of good results which were not always obtainable in instance of old-standing frontal sinus disease, especially where marked polypoid changes of long duration existed. During the after treatment he objected to the usual method of fixing the dressing by means of bandaging the head, and said that he had found a protection shield, which he exhibited, very useful. It was used with the same object as the aural shield that he applied after mastoid operations. This protection shield prevented pressure on

the wounded and contused parts and encouraged drainage and healing by first intention, which were of the greatest value in diminishing scar and deformity. There was an additional advantage gained in the employment of this shield, because the elastic pressure assisted passive serous congestion, and in the manner of a Beir's band determined a large supply of blood serum to the part and so greatly aided primary union. This probably accounted for the average number of days that these patients were in hospital being only five. In all these cases the disease was of long standing, varying from three to twelve years, and seemed in three of them to originate in influenza.

The symptoms were periodically very greatly aggravated, and on such times the chronic supra-orbital pain became unbearable. One of the cases operated on a month ago afforded an example of an unusual procedure. Through a skin incision of not more than one inch and a quarter the frontal sinus cavity on the same side was cleared of mucous polypi. A partition between the two sinuses was then broken down, and the opposite frontal sinus was similarly cleared, being found packed with mucous polypi. Mr. Stuart-Low pointed out how the two sides had been radically cured. Drainage was accomplished from both sinuses down into the nose through one tube. This patient had been subject to epileptic fits, and had one while in hospital, but since the operation on the frontal sinus she had had no attack. Frontal sinus disease might be a causal factor in epilepsy. This had not been suspected hitherto, so far as he knew, and it would be interesting and instructive to look out for corroborative evidence.

Dr. DONELAN said an interesting point was the cessation of the epileptic attacks. He had a young lad who suffered from epileptic attacks two years ago. Polypi were removed from his middle meatus, and the attacks had not recurred since. He had looked up some of the literature, and the only reference he could find to epilepsy being due to anything of the kind was Fére's article in *Twentieth Century Practice* referring to a case of Lasaulle's, in which "foreign bodies" in the frontal sinus had caused such seizures.

The PRESIDENT said he thought the cosmetic result in all the cases was very good.

Dr. PERMEWAN said that in one of the cases there was a good deal of pus inside the nose. The external results seemed perfect.

Mr. STUART-Low, in reply, said the case in which Dr. Permewan said there was still a drop of pus was operated upon as long ago as August last. It was a very bad case and had been under treatment ten years. The pus now came from the posterior ethmoid cells, and, if this continued, a Killian's operation would become necessary. Her frontal sinus was found to be packed full of polypi, and it was impossible to cure such a case by attacking the ethmoid region alone; this would be futile. One

must operate on the frontal sinus. Killian's operation had not yet been done on any of the patients.

FOREIGN BODY REMOVED FROM THE LEFT BRONCHUS OF A MALE,
AGED NINETEEN.

Shown by Dr. D. R. PATERSON. This was a broken shell of a Spanish nut which a young sailor aspirated into his air-passages. There was a severe suffocative attack, which was relieved by the displacement of the foreign body downwards. When seen twelve hours later there was much wheezing but no physical signs to indicate its position. He was put under chloroform, which he took badly, there being much cough and cyanosis. Cocaine was applied to the air-passages and a Killian's tube of 9 mm. diameter introduced. The right bronchus was explored and found empty. In searching the left bronchus something was found blocking the entrance, but its relations were difficult to make out owing to insufficient illumination from a worn-out lamp. The examination was suspended, and on the following day, with a new lamp, patient was again put under chloroform, which this time he took quietly. The tube was at once passed down to the left bronchus, when it was seen that the nutshell lay inside the bronchus with a sharp, hook-like process over the bifurcation. With Killian's long forceps it was readily seized and drawn out. The nutshell was red in colour, which made it difficult to distinguish its relations clearly from the surrounding injected mucous membrane. A good light facilitated this and extraction was easy.

MAN, AGED SEVENTY-FIVE, SHOWN AT JUNE AND NOVEMBER MEETINGS,
1906, WITH INOPERABLE CANCER OF THE FAUCES, THE PHARYNX,
THE TONGUE, AND THE CERVICAL GLANDS, TREATED BY A
BACTERIAL VACCINE OF *M. neoformans*.

Dr. SCANES SPICER brought this case again for the inspection of the Society. The treatment had been continued as before. The faucial growth was smaller, and at some portions of margins looked like cicatrising. The cervical glands were very large, matted, and dense again. General condition as before. In the last report, vol. xiv, p. 9, reply: for "eighteen" months read "eight" months.

MAN, WITH CANCER OF LARYNX AND PHARYNX, PREVIOUSLY SHOWN
 NOVEMBER AND DECEMBER MEETINGS, 1906, AND JANUARY,
 1907, UNDER SAME TREATMENT.

Dr. SCANES SPICER again brought this case for inspection. It was the case originally brought before the Society by Dr. Watson on November 2, 1906, and which has since been under Dr. Scanes Spicer's observation in St. Mary's Hospital for treatment by a vaccine as above. The injections have been made as before in inoculation department under direction of Sir A. E. Wright and regulated by opsonic index to *M. neoformans*. The local appearances as to amount of swelling vary without recognisable cause. The superficial extension of the ulceration is trifling, if any; no part is now affected which was not described as affected in first report, so that it may fairly be said that the progress of growth, if not arrested, has been retarded to a degree which is unique in cancer of this region, as far as the speaker's observation has gone. The hoarseness and effort in speech varies, but the patient states he swallows well and has less pain, and less often. His weight two months ago was 8 st. 11½ lb. To-day it is 8 st. 11¾ lb. on same scales in St. Mary's Hospital. Patient states his weight on admission in November was 8 st. 11 lb.

Dr. WATSON WILLIAMS remarked, as Dr. Spicer had taken on the case from him, that, although he could not agree that the progress of the disease had been arrested, he thought its extension had been remarkably delayed. It was four months since he saw the case, and the disease was then rapidly progressing. It had certainly progressed since then, but more slowly than he would have anticipated.

MICROSCOPIC SPECIMEN OF A LIPOMA OF THE TRACHEA.

Shown by Dr. J. MIDDLEMASS HUNT. The patient, a man, aged sixty-eight, came under my care on November 22 of last year. He was suffering from severe dyspnoea, which had been gradually increasing for over two years. On laryngoscopic examination the larynx was found to be normal, but the lumen of the trachea appeared almost completely blocked by a smooth, rounded, pale-pink, solid-looking growth, which evidently sprang from the posterior wall of the trachea. The top of the growth was on a level with the lower border of the cricoid. I diagnosed the growth as a fibroma.

In view of its size, its firm consistence, and broad attachment,

as well as the urgency of the dyspnœa, I decided it would be best dealt with by an external operation. This was successfully carried out by Mr. Paul, one of my surgical colleagues. The growth, which was the size of a hazel-nut, was found to be attached by a broad base to the posterior wall of the trachea, opposite the first three rings. Microscopic examination showed it to be a pure lipoma.

So far as I can find, no case of lipoma of the trachea has ever been recorded. In fact, the only instance in which a pure lipoma has been met with below the larynx is one recorded by Rokitansky in 1851. In that case the growth, which was situated in the left bronchus, was discovered accidentally during a *post-mortem* examination.

MICROSCOPIC SECTION FROM A TUMOUR OF THE NASAL SEPTUM.

(The Case was exhibited at the February meeting.)

Shown by Dr. FURNISS POTTER. The report of the pathologist was to the effect that "the mucosal covering of the septal cartilage is replaced by vascular granulations containing foci of tubercle."

PROCEEDINGS OF THE LARYNGOLOGICAL SOCIETY OF LONDON.

One Hundred and thirteenth Ordinary Meeting, April 5, 1907.

J. B. BALL, M.D., *President, in the Chair.*

HENRY J. DAVIS, M.B., }
W. JOBSON HORNE, M.D., } Hon. Secretaries.

Present—26 members and 1 visitor.

The minutes of the previous meeting were read and confirmed.

The following communications were made :

A CASE OF MALIGNANT ENDO-LARYNGEAL GROWTH IN A MAN, AGED TWENTY-NINE, SHOWN AT THE LAST MEETING (*vide* "PROCEEDINGS," MARCH 8, 1907).

Shown by Dr. STCLAIR THOMSON. A portion of the growth was removed shortly after the Meeting, and found to be carcinoma. Although there was a small gland on one side of the larynx, it was thought that an attempt might be made to operate on this separately and clear away the endo-laryngeal growth by a laryngo-fissure. However, on starting the latter operation, the small gland lying on the crico-thyroid membrane was found to be infiltrated with hard growth, and as the disease had therefore spread through the larynx it was hopeless to think of eradicating it by thyrotomy. A tracheotomy tube was therefore left in, and the patient allowed to recover from the anaesthetic. When he was offered the alternative of excision of the larynx, he declined it.

The case was, of course, highly interesting from the early age of the patient. A microscopic section was exhibited.

Dr. JOBSON HORNE said he looked at the section, but was unfortunate in not being able to find that part of it which contained the carcinoma. He thought it would be well to refer the section to the Morbid Growths Committee for an opinion.

Mr. BETHAM ROBINSON seconded Dr. Horne's suggestion to refer the section to the Morbid Growths Committee. As some of the sections

were cut obliquely, and others did not clearly demonstrate the presence of carcinoma, that would be a wise course.

Dr. STCLAIR THOMSON, in reply, agreed to the suggestion. He had only received the section that afternoon. He had also the section of the gland which he removed from the front of the crico-thyroid membrane.

A CASE OF SO-CALLED PROLAPSE OF THE VENTRICLE OF MORGAGNI, IN A WOMAN, AGED FIFTY, SHOWN AT THE LAST MEETING (*vide "PROCEEDINGS," MARCH 8, 1907.*)

Shown by Dr. STCLAIR THOMSON. The growth was removed in one piece, and under the microscope showed œdematosus tissue with a very slight fibrous stroma.

The PRESIDENT thought it would be well to refer this case also to the Morbid Growths' Committee, as it was a very rare specimen.

Dr. HORNE, referring to Dr. StClair Thomson's remark that, so far as he could recollect, a similar specimen had not previously been shown to the Society, reminded members that some years ago he, Dr. Horne, showed before the Society a microscopic section cut vertically through the soft parts of one side of a larynx, showing the growth *in situ*, which, clinically, would have simulated prolapse, though under the microscope it was seen to be a genuine hyperplasia of normal structure. That section was illustrated in the "Proceedings," vol. v, 1898, p. 98.

A CASE OF APHEMIA.

Shown by Dr. H. J. DAVIS. This was the case of a boy, aged twelve, who, according to his mother's statement, "had never spoken, though he could hum airs in perfect tune."

The boy was unusually intelligent, could draw well (with his left hand), heard and understood everything perfectly, but he could not utter a word.

Though the frænum of the tongue was short, this was not sufficient to account for his inability to protrude the tongue when under examination. The larynx was normal and there were no post-nasal growths.

At the age of three and a half the mother noticed some weakness on the right side (infantile hemiplegia?) but this was indefinite, and the child had made no attempt to speak even before this.

If asked to draw a bird, or a wheelbarrow, or cart, he did so immediately, and when asked to write under the drawing what it represented he did so. When holding the pencil in his right hand he would stare vacantly at the paper, and he could do nothing, not even write his name; but if allowed to hold the pencil with both

hands he drew and made words correctly. The condition was not so much one of aphonia as of aphemia.

The movements of the palate were symmetrical but, the exhibitor thought, slightly impaired, and the tongue was not under complete control. He would be glad if members could offer opinions as to suitable treatment. The case, he thought, was a very unusual one.

The PRESIDENT remarked that he noticed the boy could not protrude his tongue.

Dr. J. DONELAN thought the case would benefit by education, as the intelligence was preserved in so marked a degree. The paresis of the speech organs apart from the larynx seemed chiefly from desuetude. Special attention should at first be given to the vowels. He had a very similar case six years ago—an Italian boy, who was sent to a deaf and dumb institution near Rome. He learned from a relative a few months ago that the boy had greatly improved and could speak very well. He was not deaf. In these growing patients, where the intelligence was so well preserved, in cases of right hemiplegia the third right frontal convolution could be trained to take on the functions of the left in a remarkable degree. He suggested that this boy should be sent to some similar institution. The case he referred to was under training for two or three years.

Dr. DUNDAS GRANT said there seemed to be considerable weakness in the muscles of articulation when used for other purposes. The boy could not whistle, nor blow out a light, nor puff out his cheeks, nor protrude his tongue, and, as he also had incomplete action of the palate, there might be some defect in the medulla. When asked to phonate the palate dropped, although it rose reflexly when the tongue was depressed. There was, therefore, much mechanical defect, apart from the cerebral. Education might eventually be successful, but it would be a very slow process. He suggested that the case should be brought before the Neurological Society.

Dr. WATSON WILLIAMS thought there must be a cortical lesion. The mischief was fairly extensive. Yet there was no obvious atrophy in the arm, nor in the tongue, and if it were medullary, with involvement of the nuclei supplying the muscles of those regions, *i.e.*, of the lower neurones, there would be atrophy of the involved muscles. He suggested that the lesion was in and around the neighbourhood of Broca's convolution: then the arm would be affected only on one side. He asked whether there was a clear history of an attack of hemiplegia coming on at the age of three. The mother seemed very indefinite about the onset, and he gathered from her that most of the defects observed dated from birth. The patient might have had a cortical injury at birth. He agreed with Dr. Donelan's suggestion to send the child to a deaf and dumb institute, for the case was analogous to many of the cases which were successfully treated by oral methods, and the fact that the boy heard better than some of those treated in that way was favourable to such a course. There was much difficulty in getting the constant and patient training required in any other way.

Dr. DE HAVILLAND HALL said the treatment of deaf and dumb cases was a very slow one, and required immense patience and perseverance on the part of both teacher and patient. He had been watching for nearly two years a patient who was being treated so, and who had previously

been quite neglected. He was under a German gentleman and could now make himself understood. In the case before them the boy heard well, and was intelligent, and it was a question of educating the muscles. Whether permanent damage had been done, or whether the right side could take over the functional activity, he did not know. It seemed, however, to be a case which should be trained, but the mother should be informed that the treatment was a matter of years.

Mr. C. A. PARKER said he had treated several boys and girls who had cleft-palate speech simply from lack of use of the palate—purely functional cases. When this present patient phonated he at once let all the air come through his nose, and his palate dropped on to the base of his tongue. All such cases which he had seen had been cured by teachers for the correction of stammering, and this patient should do well, unless the atrophy of his tongue had rendered articulation impossible.

Dr. DAVIS, in reply, said the point was this, if the boy could not speak because his tongue was paralysed, no amount of teaching would make the hypoglossal nerve take on its functions again. Though there was supposed to be a history of right hemiplegia, it was very indefinite, and if there had been haemorrhage on the left side of the brain, the right side would have assumed the functions by now. If the boy took a pen in his left hand he was able to write, but if he held it in the other hand he could not think of, or write, the required word. It was not that the tongue was tied by the shortened frenum, but he had paresis of the anterior fibres of the genio-hyoglossus. But it could not be very extensive, because the tongue was fairly developed. The boy was unusually intelligent, and had the musical centres well developed—he could hum a hymn, or "God save the King," perfectly,—and the musical centre was almost in contact with that for speech in Broca's convolution. In reply to Sir Felix Semon, he thought that it was recognised that the musical centres had been located, and were situated behind the speech centre on the left side.

Dr. DUNDAS GRANT said there was a reference to such a centre having been proved by *post-mortem* examination, in a new book on the treatment of diseases of the voice, by Pertier, of Lyons. He did not know the details, but could supply the reference; or he would bring the subject forward for discussion. Dr. Grant considered the bilateral character of the defects difficult to reconcile with the purely cerebral origin suggested by Dr. Watson Williams.

Sir FELIX SEMON said he thought it was impossible, on the strength of a single case in which a certain faculty was absent, to localise the cerebral seat of the latter by one *post-mortem* examination. He would be interested in learning the reference which Dr. Grant had promised.

The PRESIDENT said he agreed with those who believed that the boy could not be trained on the lines of the deaf mute: there was something very special about this case, a difficulty in moving the tongue and lips. It was different from the case of the deaf mute, who did not learn to speak merely because he was deaf.

A CASE OF DESTRUCTION OF THE COLUMELLA AND PORTION OF THE NASAL SEPTUM.

Shown by Dr. DONELAN. The patient was a man, aged thirty-

five. He had presented himself in the out-patient room of the Italian Hospital fifteen months ago. At that time his nose was enormously swollen, and had many of the characters of lupus. There was ethmoidal suppuration, especially in the right nostril. No history of syphilis could be obtained. Patient denied having had any other local sore, sore throat, or rashes. He attributed his disease to a bad smell from a drain-pipe he had been repairing.

A series of mercurial inunctions was immediately given, and this treatment, alternated with mixtures containing corrosive sublimate and potassium iodide, was kept up for six months; afterwards the treatment consisted of the mixtures only. The condition of the nose improved from the first, except the ethmoidal suppuration, which still continued. The lower portion of the cartilaginous septum was destroyed, except a narrow strip of its anterior margin, which was now the sole support of the tip of the nose. He had not seen the patient for over a month until the day previous, when he was arranging to show him here with a view to asking the opinion of members as to whether any plastic operation might be undertaken with advantage.

The PRESIDENT said the appearance of the nose was normal until it was turned up. It should not be very difficult to fashion something to take the place of the septum in front.

Dr. DONELAN wished to point out, before the discussion proceeded, that there was now a suspicious pimple on the tip of the nose, and he wished to hear whether there might not be lupus as well as syphilis in the case.

Dr. H. SMURTHWAITE said that, having no cognisance of the treatment, one would regard it as a case of lupus, especially as the cartilage had been affected and the process had stopped at the bone. The suspicious pimple also simulated lupus. He thought some mechanical treatment would be advisable. Surgery would result in contractions occurring subsequently, thus making the appearance worse. He suggested a flesh-coloured celluloid septum.

Mr. HERBERT TILLEY said he would not like to have to express an opinion as to whether the condition was lupus or tertiary syphilis. If it should prove difficult to get the wound to heal at the limit of the cartilage the trouble might be overcome by resecting the mucous membrane well on to the vomer, freshening the edges of the mucous membrane, and then letting them heal. These edges would thus be in the region of healthy mucous membrane. He did not agree with Dr. Smurthwaite with regard to mechanical appliances for correcting the deformity. Such might serve if the patient did not blow through the nose or otherwise move it, but in practice all mechanical contrivances were found to be irritating, and did not answer well. They were just as unsatisfactory as bougies for dilating mechanical obstructions; patients found them irritating after the novelty of wearing them had passed off. The speaker suggested it would be well to dissect up a strip of mucous membrane on the under surface of the upper lip and pass it through a hole cut between the upper

lip and the floor of the nose ; the tip of this strip must then be secured to the freshened tip of nose. He referred members to the work of Roe, of Rochester, U.S.A. The particular method he had just mentioned was easy and the results excellent.

Mr. WHITEHEAD said he would have no doubt that the case was one of lupus, and he did not think it could be regarded as cured at present ; there seemed to be still some active ulceration. To cure that, probably the best thing, as Mr. Tilley suggested, would be to bare and remove the edge of the cartilage. Any operative procedure until the cure had resulted would probably be disastrous. Dr. Roe's operation, as described by Mr. Tilley, sounded easy. He (Mr. Whitehead) had not tried it himself. There might be some difficulty about the hair, which might grow into the nose.

Mr. TILLEY, in reply to Mr. Whitehead, said Dr. Roe referred to that point in his description, stating that at first the hair grew, but in time the follicles degenerated, and long hair ceased to form. But even if the hair continued to grow long in its new situation the deformity would be much less than the man exhibited at present.

Dr. FITZGERALD POWELL said that in the present case it was not necessary to use the skin of the lip where hair grew ; sufficient tissue for the purpose could be got from the floor of the nose.

Dr. DAVIS thought there was not much disfigurement in the case. The patient was a short man, and most people would not notice anything abnormal about him unless he raised his head.

Dr. STCLAIR THOMPSON said the case seemed to him to be one of lupus, and if any attempt at forming a natural columella were contemplated it should be remembered that the tissues there were of very low vitality and the attempt might fail ; and if it succeeded, contraction might set in, and if the tip of the nose were drawn down, it would be uglier than at present.

The PRESIDENT said he would favour a mechanical contrivance for the case, in spite of Mr. Tilley's remarks, and he thought the reference to the intolerance of the nose for bougies did not apply. It was simply necessary in this case to supply an artificial columella, and this would be preferable to running the risk of a plastic operation which might not give a satisfactory result.

Mr. TILLEY, in further comments, suggested that the remarks of Mr. Whitehead did not apply to the case. He (Mr. Tilley) would turn up a piece of mucous membrane from the upper lip, and make a hole through the upper lip communicating with the floor of the nose, bring the flap of membrane up through the hole, and fix it to the tip of the nose. Then the epithelium became squamous and dry.

Dr. DONELAN, in reply, thanked the various speakers. It was with some hesitation he had at first ordered mercury and iodides in this case, as the appearances were very suggestive of lupus. The remarkable improvement in the first week warranted him in continuing the mixed treatment, and it had been taken with unvarying benefit for fifteen months. He had not seen the patient for a month, and it was only now he noticed the pimple to which he had referred. He thought it might be well to observe the case a little longer before deciding to do anything.

A CASE OF PHARYNGO-KERATOSIS STEADILY IMPROVING UNDER APPLICATIONS OF SALICYLIC ACID IN SULPHO-RICINATE OF SODA.

Shown by Dr. DUNDAS GRANT. The patient was first seen in March, 1906, when she complained of soreness of the throat of three months' duration. On inspection there was found well-marked pharyngo-keratosis. Various isolated applications were made; in the first instance a saturated solution of salicylic acid in alcohol to the spots on the right tonsil, the galvano-cautery to those on the left one, then pure formalin to the left one, and a 10 per cent. solution of sulpho-ricinate of soda to the right. In April she was given a 1 per cent. solution of formalin in glycerine and distilled water, which she applied daily for a month, at the end of which time comparatively no change had taken place. In April, 1906, she commenced the daily application of a 10 per cent. solution of salicylic acid in sulpho-ricinate of soda *to the right tonsil only*; a slow but steady diminution in the size and in the consistency of the spots was observed after a few weeks, and she was then instructed to make the application to both sides; very gradually but steadily this change has continued, until now there is scarcely a vestige of the disease remaining. The patient complained at times of the application producing a dry feeling in the throat at night, but she was very anxious to get rid of the spots, in spite of the fact that she was assured that their presence was not detrimental. The exhibitor would be glad if members of the Society would give the application a trial on any of their marked cases.

The PRESIDENT said he understood the case was shown to exemplify the efficacy of salicylic acid in the cure of the case. But it had been used for a year and the case was not quite well yet. A few years ago salicylic acid was put forward as an absolute cure for mycosis in a strength of 25 per cent. in spirit. There was, at that time, a nurse in the West London Hospital who had very marked mycosis, and he thought it would be a good opportunity to try the remedy. She had it applied, either by himself or by a resident, once every other day. She left at the end of three months, and the best he could say was that the condition was just a little better than before the treatment was commenced. Since then he had not had much faith in the treatment.

Dr. F. DE HAVILLAND HALL said pharyngo-keratosis was very much like warts elsewhere. Sometimes they would disappear in a marvellous way. Once he had a barrister with the condition, which annoyed him in his profession; it was at about the date when the salicylic treatment was first introduced. He applied it himself and instructed the patient how to do so. After three or four months the patient gave it up in despair and was lost sight of. But he heard since that it got well. In view of

the present case he would write and ask about the further progress of the case.

Sir FELIX SEMON asked why keratosis must be treated at all, seeing that it always got well of itself. There was no real remedy for the condition; constant applications rendered the patient needlessly nervous, and greater importance was attributed to the malady than it deserved. Moreover, the man who treated such a trifling condition for a long time exposed himself to recrimination. He wished the profession would recognise that keratosis occurred when the patient was run down, and that it would disappear under a change of air and tonic treatment. No local treatment was necessary.

Dr. FITZGERALD POWELL thought Sir Felix Semon's plan would have a serious mental effect on the patient, who thought he was suffering from a real disease, and if something were not done for him he would feel that he had not been justly dealt with. His cases had generally got well after the application of the cautery.

Mr. HERBERT TILLEY said that six months after a discussion on the subject before the Society he became a sufferer from pharyngo-keratosis. The general opinion then held was that if left alone the disease would do quite well, and consequently he did nothing for it. It lasted five months, and the symptoms which troubled him most was an irritating cough, which came on very suddenly. In a week the whole condition disappeared without any discernible reason, and during the whole period of its presence he was in good health. Had he applied any local applications he would probably have attributed the cure to their influence.

Sir FELIX SEMON, answering Dr. Tilley, said he would like to know how he proved a connection between the cough and the keratosis. Sir Felix did not believe keratosis would cause cough. No doubt the galvano-cautery, as mentioned by Dr. Fitzgerald Powell, would get rid of the exudation, as would any other mechanical appliance, but after curing the patient he would be found, possibly already a week later, to have keratotic spots as much as ever. That was what naturally made the patient nervous and anxious. He spoke from a large experience of such cases. The question was whether the medical man ought or ought not to do something if the patient wanted "something to be done." In such a case Sir Felix thought the practitioner served his own interest, the honour of his profession, and the interest of the patient best by not yielding to the patient's wish. Even if the patient, in consequence, went to someone who had not the same compunctions, the practitioner could at least "sleep well in his bed."

Dr. JOBSON HORNE said some years ago, after hearing a similar expression of opinion at a meeting of the Society, acted in accordance with it, declining in a case of keratosis of the fauces to do any local treatment. The patient's friends resented that, and he (Dr. Horne) was asked to do something more for the throat. He therefore applied a solution of formalin, and by the next visit the condition had cleared up, whether because of the formalin, or spontaneously, it was difficult to say.

Dr. DUNDAS GRANT, in reply, agreed with Sir Felix Semon, and said he had acted upon the principle which he had stated, regarding it as the correct one. He put before the patient, as was his custom, the fact that the appearance of the throat was of no significance, but the girl insisted upon trying something for it, and he therefore allowed her to use the remedy he had mentioned for herself. The discomfort she had gone through in using it, he thought, was out of proportion to the result. She used it for

one tonsil first, and the change in it was unmistakable. He thought it was his duty and privilege to bring the case before the Society as a properly conducted experiment, though he did not say he would recommend the treatment in every case of the kind.

Mr. TILLEY, in replying to Sir Felix Semon's question concerning the relation between the cough and the keratosis, said it was a cough of a kind which he had never before experienced; the disease produced a feeling as if a needle were scratching the mucous membrane. The cough was spasmodic and very violent, and he had never suffered from it before the keratosis appeared nor since its disappearance.

CASE OF IMMObILITY OF THE LEFT VOCAL CORD.

Shown by Dr. DUNDAS GRANT. The patient, a woman, aged forty-one, complains of pain in the back of the neck and choking in front of the throat, which has lasted, on and off, for fourteen years. She has occasional attacks of hoarseness; the breathing is noisy during sleep. At the present time there is complete fixation of the left vocal cord in the cadaveric position, or probably somewhat internal to it. The tissues of the larynx behind and below the left cartilage of Santorini appear to be bulging slightly, and not very definitely, into the pharynx, making the hyoid fossa of the left side extend less far backwards than on the right. There are no physical signs, and no radiographic evidence of disease in the thorax. There is occasional difficulty in swallowing, which appears to be spasmodic; no oesophageal instrument has as yet been introduced. There are no enlarged glands, and no apparent involvement of any other cranial nerves. The exhibitor would be glad of opinions as to the diagnosis between paralysis and mechanical fixation, and, if the latter, the possible nature of the local disease.

Dr. WATSON WILLIAMS regarded the laryngeal appearances and the history as suggestive of syphilis, and in her larynx he found that some contraction and adhesions remained. The right vocal cord, as well as the left, he thought, was involved. She seemed to have cicatricial contraction of the left aryepiglottic fold. As regards her mother's family history one child was born dead, and he believed she had lost another. He could not see on her fauces any evidence of syphilis, but she suffered from intense bitemporal neuralgic headaches, and he would like to know if there was anything about her to support the suggestion of syphilis.

Sir FELIX SEMON regarded it as a case of mechanical fixation. There was considerable enlargement of the left arytenoid cartilage at its base, and it looked as if the left crico-arytenoid articulation were fixed. The right vocal cord was badly abducted, and she had not merely stridor in respiration, but some difficulty in swallowing, and that pointed to a considerable thickening of the cricoid plate. It might be syphilitic, and the abduction of the right vocal cord could be explained in that way. He advised energetic anti-syphilitic treatment.

Dr. GRANT, in reply, said there was a diffuseness of the swelling on the left side which biassed him in favour of the mechanical theory. He would certainly treat her with anti-syphilitic remedies.

A CASE OF THORACIC LYMPHO-SARCOMA, WITH CLINICAL AND PATHOLOGICAL OBSERVATIONS.

Shown by Dr. JOBSON HORNE.

Clinical history.—The patient, a man aged forty-nine, was quite well up to two months previous to his death, his weight being fifteen stone. He first noticed an increasing inability to eat meat, and within a month of the onset of this difficulty he was unable to take solid food, the attempt causing vomiting. He was able to take liquids by drinking fast, only about a teaspoonful returning from three quarters of a pint. Five weeks after the onset of the dysphagia—that is, three weeks previous to his death—there developed difficulty in breathing, which became worse, and was attended with “occasional spasm of the windpipe,” so that he had to sit up. Latterly the attacks became more frequent, recurring twice a day, and lasting half an hour; they were worse at night, so that he was afraid to lie in bed.

Condition on admission to hospital.—He had an anxious look. There had evidently been considerable wasting. The breathing was rapid, and associated with inspiratory and expiratory stridor, and much “wheezing,” as if bronchial. He experienced a feeling as though a weight were on the chest along the sternum.

The examination of the thorax revealed no physical signs of aneurysm. Both sides of the chest moved equally; there was no area of dulness. The area of cardiac dulness was diminished; the cardiac sounds were normal. The larynx was observed to be congested, but the vocal cords moved well, and there was no sign of obstruction. A radiograph of the chest was not obtainable.

The œsophagus permitted the passing of a bougie of the largest size.

The patient rapidly became much worse, very cyanosed, and distressed, and on the second day after admission death occurred from asphyxia.

The post-mortem examination revealed in the posterior mediastinum a lobulated mass of new growth, the size of a large pear, apparently springing from the bifurcation of the trachea, and extending forwards into the pericardium and downwards and

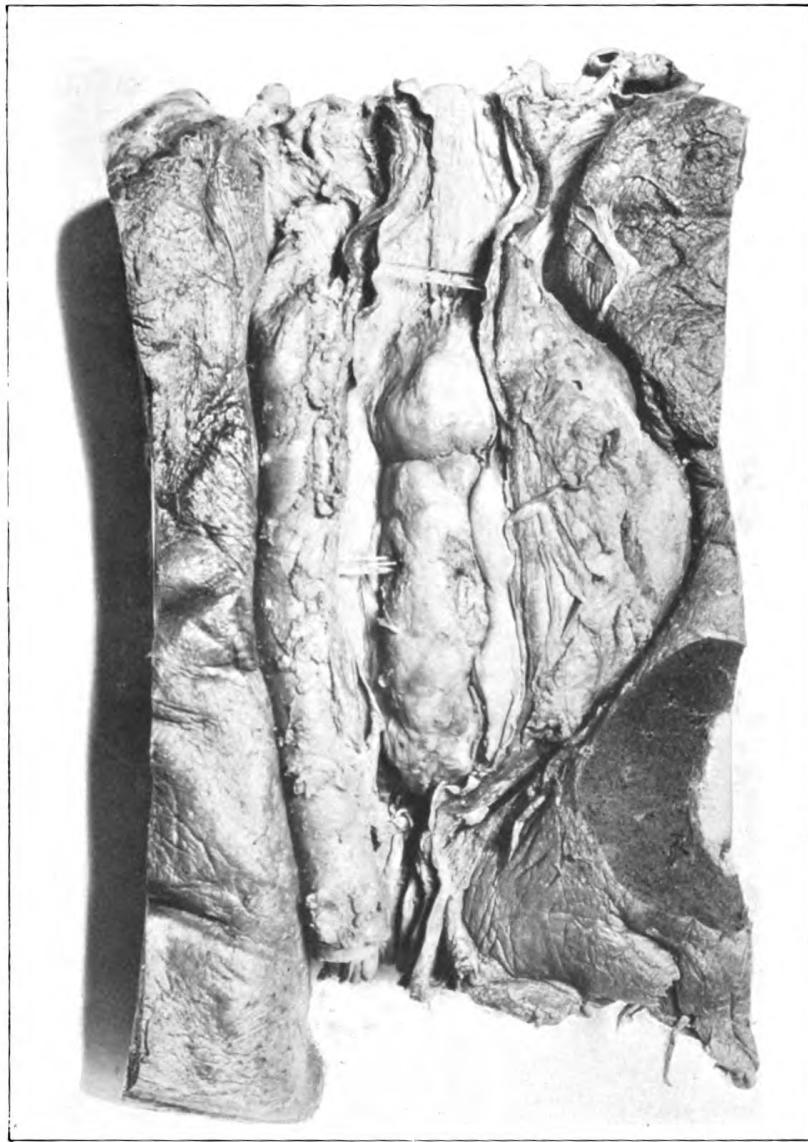


A photograph of the larynx opened from behind to show :
(1) The localised oedema over the right arytenoid. The oedema has somewhat subsided in the process of preserving the specimen.
(2) The puckered scar in the fold of mucous membrane passing down between the cartilages of Santorini and Wrisberg, and referred to by the author as the vulnerable spot of the larynx as a source of systemic infection.

TO ILLUSTRATE DR. JOBSON HORNE'S CASE OF LYMPHO-SARCOMA OF THE MEDIASTINUM.

Communicated to the Laryngological Society of London April 5, 1907.





1 2 3 4 5

A photograph taken from behind to show the invasion of the posterior mediastinum by the new growth. The structures entering into the photograph from left to right are :

- (1) The inner portion of the left lung.
- (2) The descending aorta.
- (3) The oesophagus laid open to display that portion of the growth which bulges into, and almost obliterates, the lumen to the extent of 115 mm. The walls of the oesophagus are separated by a glass rod inserted in the upper part at a level corresponding to that of the bifurcation of the trachea. The oesophagus above this level is dilated.
- (4) The main portion of the growth outside the oesophagus, and to the right of the middle line.
- (5) The inner portion of the right lung showing the direct extension of the growth into the lower lobe.

TO ILLUSTRATE DR. JOBSON HORNE'S CASE OF LYMPHO-SARCOMA OF THE MEDIASTINUM.

Communicated to the Laryngological Society of London April 5, 1907.

backwards for the most part to the right of the middle line. The growth had bulged into the lumen of the œsophagus so considerably that the mucous membrane covering it was extremely thinned and atrophied, the œsophagus itself being obstructed by the new growth to the extent of 115 mm. in the vertical direction, the growth within its walls measuring 40 mm. across, whilst the entire width of the growth in the posterior mediastinum was 70 mm. There was some dilatation of the œsophagus above at the level of the bifurcation of the trachea. Both pulmonary veins were surrounded by the growth, the right bronchus, although not invaded, was considerably narrowed. There was a direct extension of the growth into the lower lobe of the right lung. There was much surgical emphysema round the root of the right lung, and also between the chest and the pleura; the lungs were somewhat collapsed, but presented no further evidence of disease.

Microscopic examination of the growth showed it to be a round-celled sarcoma.

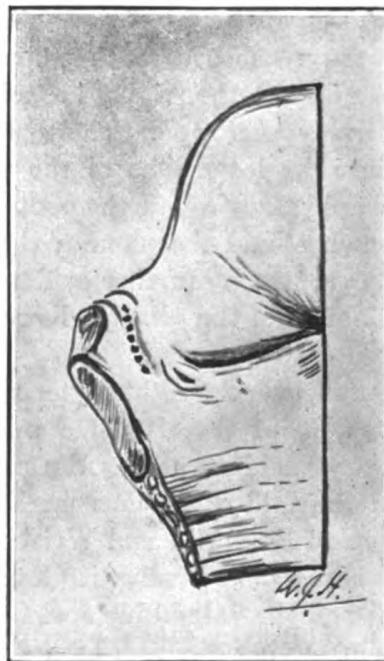
The larynx presented, over the right arytenoid region, a circumscribed area of œdema, about the size of a raisin. On the inner aspect of the right arytenoid there was the puckered scar of an abrasion, situated in the fold of mucous membrane passing down between the cartilages of Santorini and Wrisberg, a site which I have described elsewhere as one lending itself to systemic infection, and which I have termed the vulnerable spot in the larynx.¹ It is indicated in the accompanying diagram by a dotted line, and must be distinguished from the common site of a tuberculous ulcer, which is immediately behind and a little below the vocal process (the posterior sesamoid cartilage) of the vocal cord. There was no marked enlargement of the cervical lymphatic glands.

The case presents some unusual features of clinical and pathological importance:

- (1) The extent of the occlusion of the lumen of the œsophagus by an extrinsic new growth.
- (2) The possibility of passing a bougie of the largest size, in spite of such marked œsophageal obstruction, illustrates both a clinical fallacy, which may attend the use of soft rubber instruments, and also the value of œsophagoscopy in the diagnosis of such cases; it being improbable that a rigid tube would have passed the growth.

¹ Introductory paper to a discussion on "The Upper Respiratory Tract as a Source of Systemic Infection," British Medical Association Annual Meeting, Swansea, 1903.

(3) The localised œdema of the larynx might be accounted for by the conditions within the thorax. At the same time it is as well to consider the possibility of such œdema being occasioned by a local infection at the site indicated. The presence of the scar in the larynx raises the interesting question whether the thoracic growth were not the result of an infection, and whether lympho-



A diagram of the interior of the left half of a larynx to show the site referred to as the *vulnerable spot*, which is indicated by a dotted line.

sarcoma may not eventually have to be numbered, together with the lesions met with in Hodgkin's disease, amongst the infective granulomata. The question is not necessarily negatived by the absence of enlarged cervical glands, for I have shown experimentally that after an inoculation the proximal group of glands may not be permanently affected, whilst *post-mortem* a distal group may be found markedly enlarged.

PROCEEDINGS OF THE LARYNGOLOGICAL SOCIETY OF LONDON.

One Hundred and fourteenth Ordinary Meeting, May 3, 1907.

J. B. BALL, M.D., *President, in the Chair.*

HENRY J. DAVIS, M.B., }
W. JOBSON HORNE, M.D., } Hon. Secretaries.

Present—38 members and 4 visitors.

The minutes of the previous meeting were read and confirmed.

The following communications were made :

A POLYPOID GROWTH WITH DOUBLE PEDICLE REMOVED FROM THE TONSIL.

Shown by Dr. P. McBRIDE. The patient, when seen in May, 1905, had felt discomfort in swallowing for some time. A small white, lobulated tumour was seen attached to the right tonsil by a pedicle, which on examination was found to be double. It was removed with vulsellum and scissors. Afterwards it was seen that the points of attachment of the two pedicles were above and below a crypt.

TUMOURS OF THE VENTRICLE OF MORGAGNI.

Dr. JOBSON HORNE showed : (1) A macroscopic specimen demonstrating true prolapse of the mucous membrane lining the ventricle of Morgagni.

(2) A microscopic specimen cut vertically through the soft parts of one half of a larynx demonstrating a growth springing from the roof of the ventricle. Clinically it might have simulated a "prolapse" or might have been diagnosed as a fibroma of the ventricle; it was really a hyperplasia consisting of structures similar to those of the ventricular band, so that it may be described as a supernumerary ventricular band.

(3) A macroscopic specimen of part of a tonsil showing an excrescence simulating a polypus. The excrescence was composed of tissue similar to the tonsil itself but presenting degenerative changes.

(4) A microscopic section of a "polypus" attached by a long pedicle to the base of the uvula. Under the microscope the structure was that of a true papilloma.

A CASE OF SUBACUTE LARYNGITIS WITH ULCERATION ; FOR DIAGNOSIS.

Shown by Dr. H. J. DAVIS. The patient, a man, aged twenty-nine, had been hoarse for three months; there was subacute laryngitis with a small ulcer on the right ventricular band. No history of syphilis, though the palate was perforated. There was some impairment at the right apex; the condition was painless.

Dr. DAVIS said he desired opinions as to whether the case was syphilis or tubercle, or a simple subacute laryngitis.

Mr. CRESSWELL BABER said he could not see any ulcer on the right ventricular band; probably it had disappeared under the influence of the iodide of potassium. There was a slight excavation on the right cord. He thought the case was probably syphilitic.

Mr. P. R. DE SANTI thought it was of specific origin, and he would favour hypodermic injections of calomel to try and reduce the condition. The state of the palate was very suggestive of specific trouble.

Dr. McBRIDE asked whether the sputum was examined; the case as it stood now must be either tubercle or syphilis in an early stage. The eaten-out appearance of the anterior part of the right cord looked more like tubercle than syphilis, although the perforation of the palate was rather difficult to account for on that hypothesis.

Dr. Wm. HILL suggested inunctions of mercury over the larynx. He had occasionally seen iodide of potassium cause a good deal of trouble over the larynx, especially producing submucous swelling. The fact that the laryngitis disappeared under iodide did not exclude syphilis. But, in view of the perforation of the palate he would go on with the mercury.

Dr. STCLAIR THOMSON suggested that it was tubercle in a syphilitic subject. Dr. McBride had alluded to the waxy condition and the loss of substance of the right vocal cord, which could not be late tertiary, but it was like the nibbled condition seen in early tubercle. The patient said he had lost more than eight pounds in weight during the last five months, and his general health was poor. If he were treated too vigorously for his syphilis, it might bring out his tubercle, whereas if he were treated for his tubercle his syphilis would probably get well of itself. Open-air treatment was well known to improve syphilitics.

The PRESIDENT said it was a difficult case, but Dr. StClair Thomson's view seemed a very likely one. It would be interesting to have a later report of the case.

**A CASE OF A GROWTH ON THE LEFT VOCAL CORD IN A WOMAN, AGED
TWENTY-NINE; (?) MYXOMA.**

Shown by Mr. DE SANTI. This patient complained of hoarseness of varying degree, and cough of three to four years' duration. On examination of the larynx a sessile growth was seen to occupy the anterior half of the left vocal cord. It appeared to grow from the edge of the cord and looked like a gelatinous nasal polypus. It was fairly firm to the probe. On the opposite cord was a small red eminence apparently produced by irritative attrition by the growth on the left cord. Mr. de Santi thought the condition probably myxomatous in nature, and proposed to remove the growth by endolaryngeal methods.

Dr. DUNDAS GRANT thought it was an oedematous fibroma, and that a very excellent result would follow its removal.

Dr. HILL asked Mr. de Santi to bring the specimen forward if it turned out to be myxoma, as that was one of the rarest tumours of the body.

Dr. McBRIDE said there seemed to be a small growth of similar kind on the opposite cord. Years ago he had a case of infiltrating myxoma, which was the pathologist's verdict. It seemed to have all the characteristics of a malignant tumour. The case was obviously rather urgent. He removed a piece for microscopical examination, and asked the pathologist to report quickly. The report was that it was epithelioma. Half the larynx was excised, then the pathologist reconsidered the matter, prepared the tissue carefully, and found he had cut the section diagonally, and so got the semblance of epithelioma. It turned out to be a true infiltrating myxoma—not merely oedematous connective tissue.

Dr. STCLAIR THOMSON said that years ago the Society had a discussion on myxoma of the vocal cord, and he, Dr. Bond, and another member showed what they considered to be myxoma. Yet Morell Mackenzie, in his book, said he had seen only one. The three specimens were submitted to the Morbid Growths Committee, on which Dr. Kanthack's help was available. It was decided that none of the three was true myxoma, but were oedematous fibromata. At the discussion it was concluded that there was no such thing as myxoma in the larynx, the idea being that what was called myxoma was always simply an oedematous condition of fibroma, or simply inflammatory tissue.

Dr. JOBSON HORNE said there seemed some confusion as to the precise terminology of the case. He thought many such cases were really instances of cystic disease of the vocal cord, the outcome of epithelial cells having undergone degenerative changes. He thought that the terms "oedematous fibroma" and "myxoma" were both unsuitable.

**A MICROSCOPIC SECTION OF A LARYNX SHOWING A TONGUE OF THE
MUCOUS MEMBRANE OF THE VENTRICLE.**

Shown by Dr. WYATT WINGRAVE. Section of larynx (coronal) showing a peninsulated projection in the interior of the ventricle.

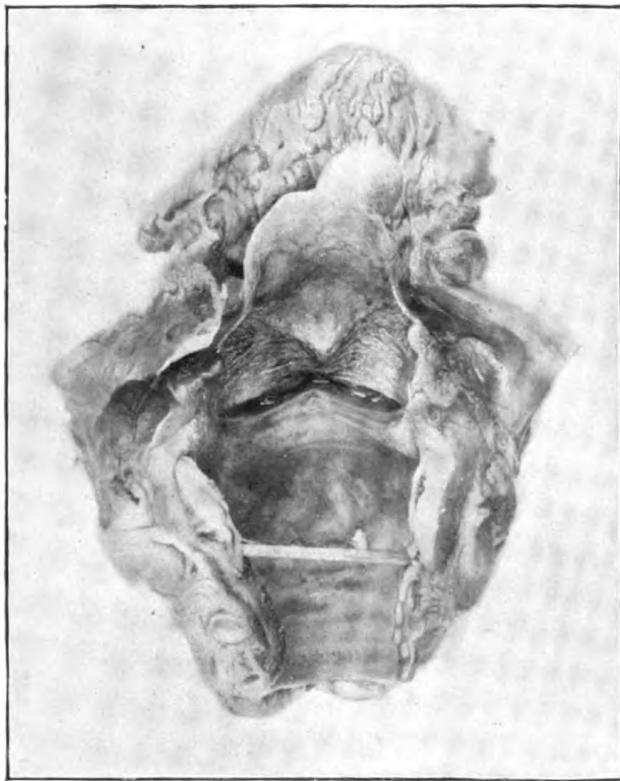
The "tongue" is attached to the outer wall and is apparently normal mucous membrane covered with columnar epithelium. It is one of four normal larynges cut for anatomical purposes, and is shown with the suggestion that it may help to throw some light upon the condition known as "eversion" or "prolapse of the ventricle."

A CURVED KNIFE FOR THE ENCLEAULATION OF ENLARGED TONSILS.

Shown by Dr. A. BRONNER. The tonsil is pulled forward by vulsellum forceps, and then quickly cut off by the knife. The bent part is pressed well back between the pillars of the fauces, and thus practically the whole of the tonsil can be removed quite as completely as by enucleation by the finger, much more quickly and with much less haemorrhage and danger to the patient. If not carefully done there is a possibility of wounding one or both of the pillars of the fauces, but with a little experience this can be avoided. If the pillars are attached to the tonsil they should be loosened before the tonsil is excised. This can easily be done with the end of the knife. It is double-edged, so that it can be used for either tonsil. Of course it is not suitable for every case. When the tonsil is soft or very flat so that it cannot be pulled forward, the punch forceps should be used, or the tonsil slit open with a sharp strabismus hook. The knife is made by Meyer and Meltzer, of Great Portland Street, W.

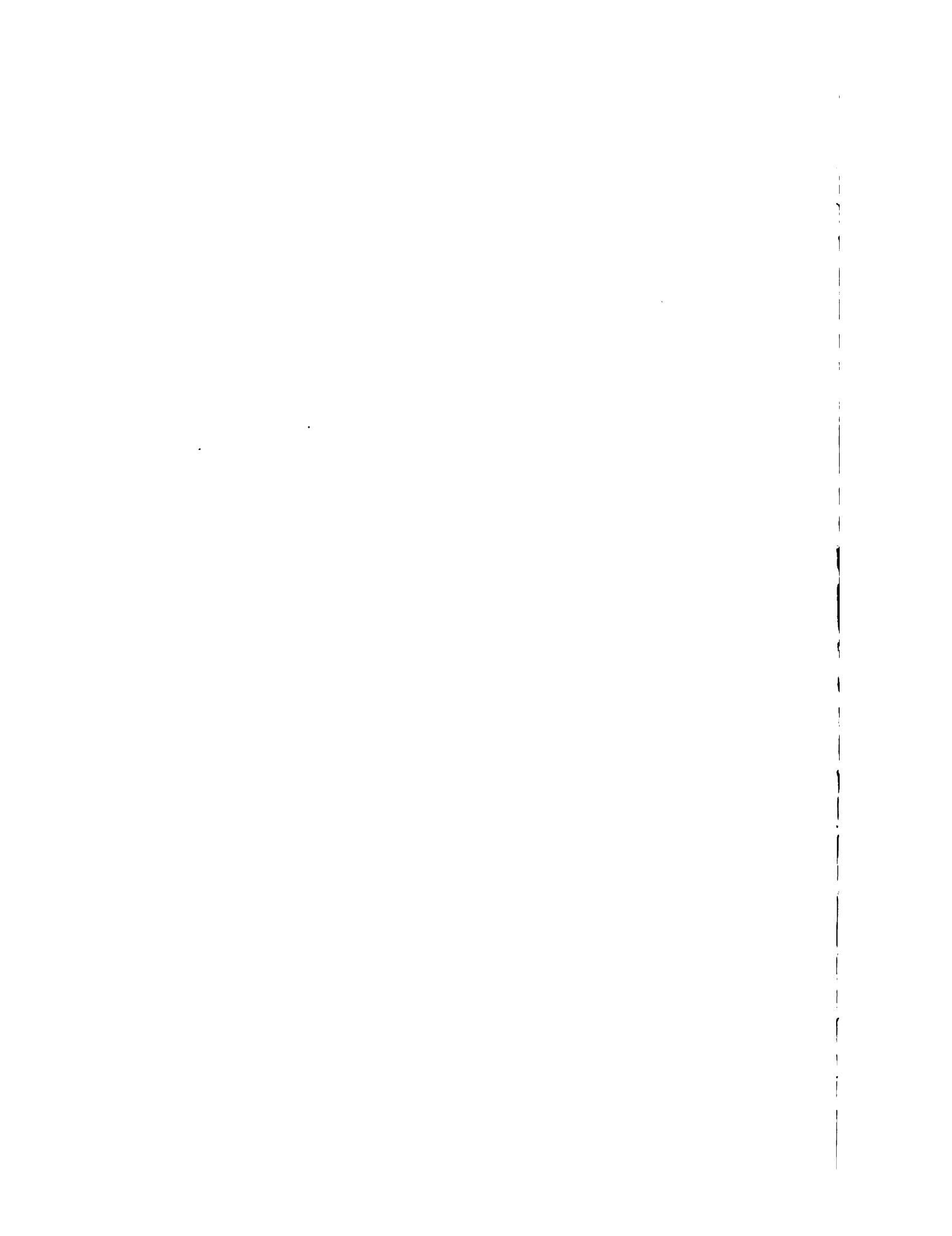
CASE OF LARYNGEAL SYPHILIS SHOWN ON JANUARY 4, 1907.

Shown by Dr. J. B. BALL. When this patient was shown at the January meeting there was some difference of opinion as to the nature of the case, although the history of several stillborn children pointed to the probability of syphilis. There was an œdematosus swelling of the left vocal cord, and some subglottic swelling on both sides, but more especially on the left side. There was fairly marked laryngeal dyspnœa present. A few days subsequent to the meeting tracheotomy was performed, and she was put on potassium iodide in full doses. The next day a profuse, fœtid, purulent discharge came from the tracheotomy wound, and some days later a probe passed upwards towards the cricoid came on necrosed cartilage. Two pieces of necrosed cartilage were removed subsequently through the tracheotomy wound. At the end of the fourth week, as the laryngeal stenosis seemed to be sufficiently



CYSTOMA OF THE EPIGLOTTIS.

To illustrate Dr. JOBSON HORNE's communication to the Laryngological Society of London, January 4th, 1907. Vol. xiv, p. 32.



relieved, and there was no more necrosed cartilage to be made out, the tracheotomy wound was allowed to close. At present the parts about the glottis are much altered in appearance. The voice is reduced to a gruff whisper, and there is a certain amount of dyspnœa on any exertion. Below the glottis, on the left side, a whitish projection is to be seen, which, it is thought, may be a fragment of necrosed cartilage.

The PRESIDENT said he showed the case in January also, and the point now was what the whitish prominent point below the left vocal cord was : was it a fragment of cartilage? Some pieces were removed through the tracheotomy wound, and when he allowed the wound to close he could not be certain that they had been entirely removed.

Dr. FITZGERALD POWELL said this was a most interesting case, and one would have to be well conversant with the history and former appearance of the condition to say what the nature of the case was ; from its present appearance nothing definite could be said as to the diagnosis. With regard to the white patch seen below the cords, he thought it was a piece of necrosed cartilage. In a case of his of syphilitic stenosis of the larynx, in which a tracheotomy had been done, a small, white mass was observed below the cords, and above the tube it was difficult to say what it was, but on an operation being performed (removal of the right half of the larynx) to enable the patient to dispense with the tracheotomy tube, the mass was found to be a portion of necrosed cartilage.

A CASE OF ROUND-CELLED SARCOMA OF THE NASO-PHARYNX.

Shown by Dr. FITZGERALD POWELL. The patient, a man, aged thirty-eight, came under observation first in December, 1906, complaining of nasal obstruction and epistaxis ; the obstruction was of six months' duration. He had been treated at Oxford in October, 1906, for nasal polypi.

On examination his general health was found to be good. There was an irregular, reddish mass extending from the right choana and basisphenoid, along the right side of the naso-pharynx to the level of the tonsil, filling up the right choana, and involving the right Eustachian cushion, deeply infiltrating the soft tissues of the naso-pharynx, causing the soft palate to bulge. The jaw was fixed. A considerable number of mucous polypi were found in the nose. A portion of the growth was removed, and the report of the pathologist was that it was a "round-celled sarcoma."

It was rather doubtful whether an operation could be done to entirely remove the disease, but the patient very urgently expressed the desire to have an operation. In consequence I thought it right to make an effort to relieve him. On January 12 he was placed under an anaesthetic. A temporary, loose ligature was

placed round the common carotid and a laryngotomy was performed, through which the anaesthesia was continued. His mouth was gagged wide open, and the pharynx plugged with sponges. The soft palate was split, and a portion of the hard palate removed with a chisel and mallet. A free incision was made as wide of the growth as possible, and it was dissected out, everything at all like growth being taken away, part of the septum, which was involved, being cut away.

The man made a good recovery. One or two curettings have been done since for the removal of suspicious-looking granulations.

Mr. DE SANTI said there was undoubtedly considerable recurrence in the case, and he did not think that at any time the whole of the disease had been taken away. There were portions of growth in the posterior part of the nose, which apparently had extended from the base of the skull, and it would now be better to leave the case alone. Operation undertaken in that locality for extensive sarcoma required more done than at first appeared. In such cases, not only had the palate to be chiselled away, but also part of the base of the skull ; and in some cases it was necessary to turn both upper jaws forward, which was a formidable operation. He did not think the whole of the growth could now be got away. He did not know why Dr. Powell put a ligature round the common carotid ; he would have thought it better to have ligatured the external carotid. He was perfectly sure of one thing—namely, that imperfect and frequent curettings did not prolong life ; on the contrary, they sometimes hastened death.

Mr. HERBERT TILLEY differed from Mr. de Santi in no further operation being desirable in the case. Five years ago he, Mr. Tilley showed specimens from five operations on one patient, who had recurrences of a large fibro-sarcomatous growth in the naso-pharynx. The patient was now well, the growth having ceased to recur as the separate recurrences were removed. Since then he had seen two other cases. One had a sarcoma removed from the posterior outer wall of the left nasal fossa, and that had recurred three times. At the third recurrence, instead of approaching it from below through the palate, he made an incision as if for removal of the upper jaw, and removed the ascending process of the superior maxilla, at the same time making an opening into the antrum. By removing the whole ascending process he came on to the outer nasal wall, and removed the recurrent growth. That was fourteen months ago. He saw the patient three weeks ago, and there was no further recurrence. He did the same thing a fortnight ago in a case of epithelioma limited to the ethmoidal region, and it was surprising what excellent room and view it gave the operator, and the growth was rendered very accessible. It was an easier method than splitting the palate, and did not disturb one's knowledge of the topography of the parts. The haemorrhage in such cases was very free (vascular fibromata, or fibro-sarcomata), and it was necessary to perform a preliminary laryngotomy, and to place a sponge above the larynx to avoid being inconvenienced by the anaesthetist, and to prevent blood getting into the larynx. He would not give up the case, but would attack the recurrences, as it was pointed out by Mr. Spencer a few years ago that those growths, though histologically malignant, were not

clinically so malignant as when they occurred in other parts of the body. He thought Dr. Powell might still prevent his case from going downhill.

Mr. STUART-Low agreed that by the method advocated by Mr. Tilley the access obtained was most efficient. He had such a case, in which the patient did very well. Last week he assisted Dr. Grant in a very extensive operation, where there was epithelioma of the antrum extending far backwards and upwards. The upper jaw was removed, and the access thus obtained was exceedingly good.

Dr. H. J. DAVIS thought there was considerable disease in the nose itself, and it seemed to have spread to the anterior part of the nose.

Dr. PEGLER said he had had a similar case under observation in which the disease had spread into the nose, and in which, on two occasions, a serious operation had been undertaken and as much of the growth as possible removed. The patient turned up again at the hospital eighteen months ago with complete nasal obstruction. He failed to come again for operation, obviously because he had his living to earn, and he did not appear to be in bad general health. Dr Pegler doubted whether further attempts at removal should be made in the present case. Such sections of this class of growth as he had been able to examine had not a definite sarcomatous structure. The section now under the microscope did not seem to represent the main mass of the growth very well; it was not sarcomatous.

Dr. JOBSON HORNE said it was necessary to make sure whether sarcoma was being dealt with or not. As Dr. Pegler had said, the section was not sarcoma, and if Dr. Powell agreed to refer the case to the Morbid Growths Committee he would perhaps supply another section. He believed that the case of five years ago, referred to by Mr. Tilley, proved to be other than sarcoma. Sarcoma of the naso-pharynx was not so frequent as the literature led one to believe.

Dr. FITZGERALD POWELL, in reply, said he was grateful for the interest his case had aroused in the Society. In reply to the remarks of Mr. de Santi he did not think Mr. de Santi was quite in a position to give very decided opinions on the case, as it would have been necessary for him to have seen the case before and at the time of operation to be at all able to judge of the procedure. The case was thought to be practically hopeless, but at the urgent desire of the patient he decided to operate. He selected the operation—a modification of Nelaton's—splitting the palate, and with the head hanging down over the end of the table on account of the tendency of the infiltrating growth to grow down towards the tonsil and palate, and not so much into the nose, the maxillary antrum also being quite free from growth, and he had found this method answer very well in the removal of large fibrous growths of the post-nasal space; besides, the face was not disfigured. He did not think there was much recurrence of the sarcoma in the nose—what was there appeared to be myxomatous. There was, he thought, some recurrence at the basi-sphenoid seen up behind the hard palate. He had removed all the growth he could possibly see or feel. It was very soft and infiltrating, and could not be got away as one complete tumour. With regard to the remarks regarding the section shown, several sections had been cut of the growth and also of the contents of the nose; he regretted he had unfortunately had the wrong section sent him, which was probably that of a polypus. He would obtain all the sections and submit them later.

DRAWING OF A TONSIL, SHOWING A BIFID GROWTH SPRINGING FROM
A LACUNA. UNDER THE MICROSCOPE FOUND TO BE COMPOSED OF
ORDINARY TONSILLAR TISSUE.

Dr. STCLAIR THOMSON brought forward this drawing and specimen, after seeing the cases of Dr McBride and Dr. Horne on the programme. The growth from the tonsil in his case had the clinical appearance of a polypus, and he had expected to find that it was a papilloma. As in the case of Dr. Horne the microscope showed it to consist of only tonsillar tissue.

CASE OF LUPUS OF THE LARYNX IN A BOY, AGED ABOUT TWELVE.

Shown by Dr. DUNDAS GRANT. Outgrowths above the vocal cords concealing them almost completely. Extreme weakness of voice. Question as to how far this is due to mechanical interference on the part of the outgrowth or how far to possible destruction of the hidden vocal cords. Is the present voice produced by the glottis or above it?

The appearance of the epiglottis is extremely characteristic, and there will probably be no difference of opinion as to the nature of the disease, more especially in view of the fact that there is, on the right forearm, the remains of a lupoid ulcer.

Mr. HERBERT TILLEY said he thought he could see the posterior ends of vocal cords.

Dr. GRANT said he would like opinions as to what the rest of the vocal cord was like, and why the patient had not a better voice. Ought he to remove the small lupoid outshoots above the vocal cords, and, if so, would he be taking away the tissues used vicariously by the boy for producing his voice?

Dr. DAVIS thought that, as it was unhealthy tissue, the sooner it was removed the better.

Dr. WATSON WILLIAMS said the condition on the right side of the nose was rather suggestive of lupus, and he suggested there should be active treatment in that region as well as in the larynx.

Dr. JOBSON HORNE considered that the growths should certainly be removed, which could be done by the endo-laryngeal method. His belief was that the tissue in question was not essential for the production of the boy's voice, in fact, his voice would be improved by its removal.

CASE OF ENDOTHELIOMATOUS INFILTRATION AND ULCERATION ON THE
POSTERIOR WALL OF THE LOWER PHARYNX IN AN ELDERLY MAN.

Shown by Dr. DUNDAS GRANT. Moderate interference with swallowing. Microscopical section shows typical endothelioma.

General condition good; no glandular enlargement. The approximation of the downward continuation of the posterior pillars of the fauces suggested a tertiary lesion, but the extreme induration (noted particularly by Mr. Stuart-Low), the negative effect of anti-syphilitic treatment and the microscopical report seem conclusive. Question as to feasibility of operation.

Dr. GRANT asked for opinion as to whether operation would be feasible; also whether the microscopical aspects showed it to be malignant in character or only semi-malignant. He would be glad to submit the specimen to the Morbid Growths Committee, but the question of operation could not long remain undecided.

Dr. PEGLER said he had no doubt about the malignancy of the specimen under the microscope, but he would require to examine it more carefully before pronouncing it to be an endothelioma. He supported the proposal to submit it to the Morbid Growths Committee.

MICROSCOPICAL SECTION OF A GROWTH REMOVED FROM THE LARYNX.

Shown by H. LAMBERT LACK. The patient, a clergyman, aged fifty-four, had been hoarse nine months. The growth involved the anterior half of the right cord and spread slightly across the anterior commissure on to the left. It was removed by thyrotomy. The sections show that the growth is a spindle-celled sarcoma. The growth had a warty appearance, was sessile and infiltrating. The right cord was immobile. It was considered to be an epithelioma.

SPECIMENS OF PAPILLOMATA REMOVED FROM A LARYNX.

Shown by Mr. HERBERT TILLEY.

Dr. JOBSON HORNE spoke in favour of the direct method of removing laryngeal papillomata in children as advocated by Dr. Paterson. With the forceps devised by Dr. Paterson it was necessary to make a considerable allowance for the kick upon closing the instrument, and with it there was difficulty in clearing out the anterior commissure—the part which the operator particularly wished to reach. With a view of overcoming these difficulties, Dr. Horne had had an instrument made by Messrs. Mayer and Meltzer, and this he would be pleased to demonstrate at the next meeting.

Dr. STCLAIR THOMSON said that he also had invented an instrument, which he would bring. It left the eye open to see along the gunwale. For the last two years he had been removing such papillomata by the Killian method. But he did not find them soft to pull away, but remarkably tough, nor did he find it so easy to get "all away," as did Mr. Tilley. At the last meeting Mr. Robinson showed a specimen of papilloma of the larynx, all of which it would have been impossible to take away except by flaying the larynx, as the growths were spread over the ary-

epiglottic folds on both sides, the vocal cords, the ventricular side of the epiglottis, and below the cords. He had been disappointed to find that the growths recurred when removed by the Killian method, as by any other.

Dr. D. R. PATERSON said there were various sizes in which the forceps could be used. He had had one made in which the end was very narrow, and which could be got into any commissure. He agreed with Dr. Thomson's remarks as to the toughness of some of the growths, especially if they were sessile. Straight forceps would not grasp them, and he had found it necessary to use Löri's curette, which he had modified to use with a Killian tube. Various sizes were made, and they were especially useful in removing small pieces of growth from below the anterior commissure.

Mr. HERBERT TILLEY, in reply, said Dr. StClair Thomson must have misunderstood him, as he knew full well the difficulty of being sure that the whole of the growths had been removed. He meant to say that one was more certain of removing growths by the direct than by the indirect method. If the growths were fairly limited, probably all of them could be got away. He maintained that papillomata themselves were not so tough as Dr. Thomson and Dr. Paterson thought. When the forceps were fixed, and the growth would not come away, it was because they grasped not only the papilloma but also the tissue from which it was growing. The papilloma was a collection of "sprays" of epithelial cells supported on a fibro-vascular stem, and was quite soft. Last Wednesday he had a demonstration of that, because at the commencement of the operation he could see the growths and pick them off, but towards the end of the operation he had great difficulty in doing so when he endeavoured to get away the bases of the growths. He would be examining the larynx again next week, and would then apply a solution of salicylic acid in absolute alcohol to the growths.

Dr. WATSON WILLIAMS exhibited a Sphenoidal Sinus Syringe.

CORRIGENDUM.

On page 77, second line from top, for "aphonia" read "aphasia."

PROCEEDINGS OF THE LARYNGOLOGICAL SOCIETY OF LONDON.

One Hundred and fifteenth Ordinary Meeting, June 7, 1907.

J. B. BALL, M.D., *President, in the Chair.*

HENRY J. DAVIS, M.B., }
W. JOBSON HORNE, M.D., } Hon. Secretaries.

Present—47 members and 3 visitors.

The minutes of the previous meeting were read and confirmed.

Sir FELIX SEMON, K.C.V.O., M.D., was elected an honorary member of the Society.

The following gentlemen were elected ordinary members of the Society:

GEORGE K. GRIMMER, M.B., F.R.C.S.Edin.
WILLIAM GUTHRIE PORTER, M.B., F.R.C.S.Edin.
ALFRED JOHN MARTINEAU, F.R.C.S.Edin.

REPORTS OF THE MORBID GROWTHS COMMITTEE.

Dr. StClair Thomson's specimen from a case of malignant endolaryngeal growth (*vide Proceedings*, April 5, 1907, vol. xiv, p. 75) was found to be spheroidal-celled carcinoma.

Dr. StClair Thomson's specimen from a case of prolapse of the ventricle of Morgagni (*vide Proceedings, ibid.*, p. 76) was a soft oedematous fibroma; it contained nothing but oedematous fibrous tissue covered by squamous epithelium. It contained no glands, nor anything suggesting that it originated from the ventricle.

Dr. Fitzgerald Powell's specimen from a case of naso-pharyngeal growth (*vide Proceedings*, May 3, 1907, vol. xiv, p. 91) consists of a hyperplastic growth of lymphoid tissue, containing giant-cells, but not showing sufficiently clear evidence for a diagnosis of tuberculosis.

Dr. Dundas Grant's specimen from a case of malignant growth in the pharynx (*vide Proceedings*, May 3, 1907, vol. xiv, p. 94) is a squamous-cell carcinoma.

Dr. Lambert Lack's specimen from a case of laryngeal growth removed by thyrotomy (*vide Proceedings*, May 3, 1907, vol. xiv,

p. 95) is a squamous-cell carcinoma, the columns of which are thinned, broken up, and in places disintegrated by granulation tissue, unusual in amount.

The following communications were made :

A CASE OF SARCOMA OF THE TONSIL, TREATED WITH X RAYS.

Shown by Dr. STANLEY GREEN. The patient, a man, aged fifty-eight, first noticed a growth on his right tonsil in June, 1906, and was under his club doctor for six weeks, but the growth got larger ; he then went to the Lincoln County Hospital, and was an out-patient under Dr. Brook, and had large doses of iodide of potassium for two months. As the growth was increasing in size and he was losing weight he was advised to have an operation ; this he agreed to and the growth was enucleated. He says that the growth did not commence to grow again until January, 1907, but then the increase in size was very rapid. When I saw him on February 22 the growth was so large that the uvula was pushed over to the opposite side and he was able to swallow only liquid food and porridge, the mucous membrane covering the growth was bright red in colour, his breath was very offensive, and his weight was 7st. 6lbs.; there was a mass of enlarged glands in his neck as large as an orange, and it was stony hard ; he had now been taking iodide of potassium for seven months. X-ray treatment was commenced the same day, and was given both externally as well as internally ; the dose was always as large as I thought the tissues would stand, and as the sittings were separated by an interval of six to seven days I never caused more than an erythema of the skin. On April 15 there was only a small nodule to be felt along the border of the sternomastoid, and I showed the patient to the members of the Lincoln Medical Society. The swelling between the pillars of the fauces was then about the size of a large walnut, and it continued to decrease in size until about a fortnight ago when he caught a bad cold, with the result that the growth has increased in size, but he can eat ordinary food, can do his work, and has already put on 8 lbs. in weight.

The case is not cured yet, but I thought it would be of more interest to the members of the Society in its present condition than it would be next session, when the growth will probably have disappeared altogether.

There were twenty sittings in all, seven external and thirteen internal, and the total time that he has been under the rays is six

hours forty-nine minutes. Microscopic examination revealed the nature of the growth to be sarcomatous.

The PRESIDENT said that apparently the point in the case was the improvement which had occurred, and on that members were not able to judge. Dr. Green said there had been a large mass in the neck, and that had now disappeared.

Mr. HERBERT TILLEY said that possibly the disappearance of some of the glandular involvement in malignant disease of the throat treated with X rays was due to the fact that the throat was made much cleaner by the treatment, and there was less septic absorption. He had in mind a case of his own, in which a large mass of malignant ulceration at the base of the tongue and the side of the pharynx was considered inoperable. There was also a large mass of glands in the neck. X rays were suggested, and they were administered with the same frequency as in Dr. Green's case. Three months afterwards practically all the glands had disappeared. It would be interesting to hear from Dr. Green whether the improvement was due to the parts becoming cleaner and there being less septic absorption, rather than that any metastasis had been caused to disappear. In answer to the President, Mr. Tilley said the growth which he had referred to became smaller and cleaner, but it was difficult to say what that was due to. He saw the patient ten months afterwards, and he seemed infinitely better. He did not know what had now become of him.

Dr. GREEN, in reply, said that what Mr. Tilley had suggested came into his mind, but there was not a foul condition present, and there was no ulceration. It was merely a large tumour, with inflamed mucous membrane, and he did not think there was enough in the throat to account for such a mass of glands in the neck unless they were malignant. The way in which the condition disappeared was very remarkable.

EPITHELIOMA OF THE LARYNX.

Shown by Dr. S. MORITZ. The patient, a man, aged fifty-three came under observation three months before his death. The tumour had already then attained almost the size seen in the photograph, the epiglottis being converted into a fungating mass and the interior of the larynx being invisible with the laryngoscope. The cervical glands were infiltrated, and the case was evidently too far advanced for operation. Speech was indistinct, but deglutition was only slightly impeded. Though the obstruction to the air-passages is apparently very great, the small amount of dyspnoea from which the patient suffered was remarkable; the air current evidently had to find its way through the upper part of the pharynx and from there through the partly destroyed posterior wall of the larynx. There was no sign of deglutition-pneumonia.

Sir FELIX SEMON said it was a very remarkable specimen. No doubt it was an absolutely fortuitous thing, but the formation of the new growth was such that it did not interfere very much with breathing, nor with

swallowing. There was a space on the left side where the air could be sucked in through a narrow chink which had been left open there. He could not remember having seen a case of malignant disease exactly like that.

A CASE SHOWING THE RESULT OF RADICAL OPERATION FOR DOUBLE-FRONTAL AND ANTRAL SINUS SUPPURATION.

Shown by Dr. WATSON WILLIAMS. The patient had undergone double radical, frontal sinus, and antral operations. On the left side the frontal sinus had been dealt with by the Killian method, and on the right by a modified Delsaux operation. The frontal sinuses were enormous, and the ethmoid cells had been very extensively diseased. The result had proved very satisfactory as regards cure of the condition, and the cosmetic results left very little to be desired, although, as was inevitable, there was some—though very slight—depression on the forehead, owing to the size and depth of the sinuses, which had to be obliterated. He had removed, a short time before presenting him to the Society, some remaining ethmoidal cells, and these, as he pointed out, had not healed, and yielded still some muco-purulent secretion. The patient had been a great sufferer for many years from asthma, which had almost incapacitated him from business. Since the operation last January he had been quite free from asthma, and there was every reason to hope that he might be reasonably regarded as a case of asthma cured by operation within the nose.

Dr. D. R. PATERSON thought the cosmetic result would have been better if Dr. Williams had left a larger ridge on the left side. It showed a ridge now, and there would have been no disadvantage in leaving a wider plate of bone there.

A CASE OF EXTENSIVE SUBMUCOUS RESECTION FOR SEPTAL DEFLECTION UNDER LOCAL ANÆSTHESIA.

Shown by Dr. H. SMURTHWAITE. He brought the case forward, not from any novelty in the operation, but merely to show how extensive an operation one could do under local anaesthesia. The operation had been done under preliminary cocaine swabbing, followed by injection of novocaine and epinephrin. The patient experienced no pain, and there was no bleeding. Most of the triangular cartilage had been removed, together with part of the perpendicular plate of the ethmoid and the maxillary crest. The specimen was shown.



EPITHELIOMA OF THE LARYNX.

Photograph of the posterior aspect of the larynx showing the epiglottis converted into an epitheliomatous tumour and the great obstruction to the air passage.

To illustrate a communication to the Laryngological Society of London,
June 7, 1907, by Dr. S. MORITZ.

Dr. J. DONELAN asked how long the operation took, and what Dr. Smurthwaite's experience had been in other cases with novocaine. He had tried novocaine frequently lately, and he could not say that it possessed any advantages over cocaine as an anæsthetic, though it may be less toxic. With regard to operating under a general anæsthetic, it was a great advantage to have the patient quite steady; the operator might be disturbed by the patient moving. He also asked what was the influence of the general anæsthetic on adrenalin. His experience had been that adrenalin did not act so well then, even if it were used a quarter of an hour before the operation. Under chloroform anæsthesia the hæmorrhage was apt to be less well controlled than when adrenalin was used for local purposes without a general anæsthetic.

Dr. STANLEY GREEN asked whether Dr. Smurthwaite had ever tried allypin in place of cocaine. The advantage afforded was that there were no toxic effects, and all met with patients who could not stand a large dose of cocaine. He also asked whether Dr. Smurthwaite usually put such cases first under chloride of calcium. His experience was that if the patient were given that drug for four or five days before the operation the hæmorrhage was almost insignificant. He considered the patient would want the anterior half of the inferior turbinate removed before he was clear on the right side.

Dr. FURNISS POTTER said that he had had some experience of novocaine in connection with submucous resections, and had been much struck by its non-toxic effect in a case which had exhibited marked intolerance of cocaine, so much so, that merely spraying the nose with a 4 per cent. solution produced symptoms. He used a mixture of equal parts of 10 per cent. solution of novocaine and adrenalin 1-1000 applied on cotton-wool and kept in position for half an hour previous to operating. The patient bore the operation—which lasted about an hour—without any complaint of pain, and showed no toxic symptoms. With regard to involuntary movements on the part of the patient, he had never had any trouble. In the cases in which he had operated under local anæsthesia, the patients had said they felt no pain except when the maxillary crest was being chiselled, or the bony septum bitten with forceps, and that then the pain was slight. He agreed with Dr. Smurthwaite that it was much more satisfactory to perform the submucous resection under local anæsthesia than to have recourse to a general anæsthetic. He had the patient lying down with the head and shoulders raised.

The PRESIDENT asked why local anæsthesia was preferable, from the operator's point of view. He had heard this stated. With regard to the question whether adrenalin acted when a general anæsthetic was employed, he was sure it acted if one took the trouble to use it properly, and to allow half an hour or so for it to act.

Dr. PATERSON said that perhaps as one who had undergone the operation under local anæsthesia he might be allowed to give his experience. It was absolutely painless, the only thing he felt being the pressure of the speculum on the nose. It lasted half an hour, and was a fairly extensive operation. He did many of his own cases under local anæsthesia. With anxious, apprehensive patients one was obliged to use a general anæsthetic. He always liked the patient in the sitting posture. If the patient felt frightened or faint, it was good to have him reclining on a couch with an adjustable back. From the patient's point of view local anæsthesia was a simple and easy matter. From the operator's point of view the position was the normal one for nose work, and one

could get a more satisfactory view of the floor of the nose, which was more difficult with the patient lying down. On the other hand, in a long sitting it was necessary to stop the operation where a general anæsthetic was used, in order to administer more chloroform, and also on the occurrence of sickness, which brought the risk of stomach contents getting into the nose.

Mr. F. H. WESTMACOTT said he had tried both forms of anæsthesia, and had found it quite easy to see the floor of the nose with general anaesthesia. He had the patient lying on the operating table, with the head well over the end, the head being held in the same position as in the operation for post-nasal growth. He had never yet taken an hour over the operation.

Dr. WILLIAM HILL thought there were at times disadvantages in doing the operation under a general anaesthetic, more especially in the matter of haemorrhage. He preferred a general anaesthetic when the patient was a nervous lady, or a person who had not any great fortitude. He had had some people collapse in the chair who had had a local anaesthetic, and in one instance this was after novocaine.

Dr. SMURTHWAITE said he had never done the operation under chloroform, and he did not like to attempt it; he followed the line of least resistance. He saw the first operation done under local anaesthesia, and he copied his teacher, and had done it ever since. If he had not seen that done in Vienna he might have used a general anaesthetic until he had a mishap. It must be admitted that a general anaesthetic was a danger, but what danger had been traced to local anaesthesia? Moreover, one could guarantee that the patient would be about sooner. He did it with the patient sitting upright in a movable chair, and directly the patient felt faint down came the chair. There was more bleeding under chloroform with adrenalin than in the case of local anaesthesia; in fact, in the latter case there was often no bleeding until after the operation. There was no bleeding until the maxillary crest was chiselled away. It was only in the last two months that he had tried novocaine. He had also been trying epinephrin, which was cheaper than adrenalin, and it acted just as well.

A CLERGYMAN WITH EXTENSIVE TUBERCULOUS LARYNGITIS, WHICH HAD RESISTED TREATMENT BY SANATORIUM METHODS, SILENCE, LOCAL ANTISEPTICS, AND ESCHAROTICS. NOW COMPLETELY CICATRISED SINCE FIFTEEN MONTHS BY LOCAL TREATMENT WITH THE GALVANO-CAUTERY.

Shown by Dr. STCLAIR THOMSON. The patient entered a sanatorium in June, 1902, with tubercle bacilli in his sputum, and involvement of the right upper lobe. He was due to return home at Christmas, 1902, with the lung process quite arrested, when he suddenly developed laryngitis, which proved to be tubercular. He therefore remained on till Christmas, 1903—*i.e.* he gave sanatorium treatment and silence another year's trial.

He came under my treatment in March, 1904, with tubercular disease of the left vocal cord, the left ventricular band, the anterior

arytenoid region on both sides, and part of the right ventricular band. The left vocal cord was ulcerated in its whole extent.

The patient was kept upon sanatorium principles, and the larynx insufflated daily with iodoform for three months. Owing to the skill and kindness of Dr. Gambier this treatment was carried out at St. Leonards.

In June, 1904, a portion of the tissue was punched out, and the wound painted with Lake's strong mixture (carbolic acid 10 parts, lactic acid 50, formalin 10, water 30). The removed portion showed tubercle. Painting and insufflations were carried out until September, 1904, when the first application of the galvano-cautery was made. In February, 1905, after six applications and strict silence, decided improvement had taken place. The patient was allowed to speak in May—*i.e.* after seven months of silence—but ten more applications of the cautery were made, extending from February, 1905, to March, 1906. At this date his larynx was soundly healed. He had re-commenced some clerical duties in November, 1905, and in May, 1906, he resumed preaching and also smoking. Last summer he acted as a continental chaplain, and last winter he not only carried out the same duties single-handed, preaching two sermons every Sunday, but he also skated, tobogganed, and luged.

He never "catches cold," or has laryngitis. When examined during respiration it will be seen that the anterior third of the left vocal cord is concealed beneath the scarred margin of the ventricular band, but on phonation a good new cord comes forward. Extensive cicatrical tissue is seen on nearly all the left ventricular band, the inter-arytenoid region, the posterior end of the right ventricular band, and the region in front of the right arytenoid, which Dr. Jobson Horne has frequently called attention to as being the vulnerable point. It will be seen that healing was established and voice use allowed after six monthly applications of the galvano-cautery, and that, in all, sixteen applications were made.

One rough sketch indicates the extent of the disease, and the other shows the sites of cauterisation, frequently eight points being made at one sitting.

Mr. BARWELL congratulated Dr. StClair Thomson on the result. Although he had not seen the case before operation, the cord was now healthy, and there seemed to be no active disease there, and there was only slight thickening of the band. It was his intention now to try the galvano-cautery in some of those cases. He thought it would act best in such a case as the present, where the infiltration was somewhat scattered and not massive. He was glad to see that Dr. Thomson employed active treatment in some cases of tuberculous laryngitis.

Sir FELIX SEMON said the galvano-cautery had recently been again warmly recommended by Grünwald in certain cases of laryngeal tuberculosis. He (Sir Felix) could not speak from personal experience in cases of tuberculosis, but he had cured a most extensive lupus of the larynx by means of the galvano-cautery. Had it not been for the perseverance of the patient, however, he would not have gone on with it. The cure, which was reported about sixteen years ago, had remained complete to the present day. He earnestly hoped the negative result of the silence treatment in this case would not deter members from trying the method, irksome as it was. He referred his hearers to a paper published that day in the *British Medical Journal*, by Drs. Bardswell and Adams, from King Edward's Sanatorium, setting forth a number of cases which had been cured, either by silence alone or by that method combined with local measures.

Dr. STCLAIR THOMSON, in reply, said he would be the last person to say anything against the silence treatment of tuberculosis of the larynx. He thought it had been a great advantage that his patient had been kept on the silence treatment during the first six months' treatment with the galvano-cautery, and this had helped to avoid a reaction. He was cured with fifteen applications of the galvano-cautery, and, if the number of sittings was small, it was compensated for by the number of punctures made at each sitting. He went deeply into the tissue until he struck healthy tissue. The tubercle had been completely arrested in the chest before the larynx was treated.

TWO DISSECTED SKULLS TO SHOW EXTENSIVE ETHMOIDAL-FRONTAL CELLS.

Shown by Dr. STCLAIR THOMSON. In both these skulls the frontal cell was small and easily reached. When viewed from above the presence of the large ethmoidal-orbital might readily be overlooked, but on viewing them from below the supra-orbital ridge it was seen that this cell ran a long way backwards and outwards in the orbital roof. The skulls were shown to demonstrate the fact that it was utterly impossible to reach such a large ethmoidal cell from the nose, and that the only way of reaching it from the outside would be by a complete Killian operation.

The PRESIDENT said if there had been any doubt in anybody's mind about the possibility of treating the anterior ethmoidal cells effectually through the nose these specimens must settle the question.

Mr. WESTMACOTT said he was still unconvinced that it was necessary to open up from the front in such cases. In both the skulls exhibited there was simply an aberration of the first basal plate of the ethmoid. In the one case the basal plate was incomplete; there was a fronto-ethmoidal cell, but somewhat external to the usual situation, and over the orbital cavity. In the half-skull there was not a failure of the basal plate, but rather a deviation. Instead of coming up in the transverse method, it was twisted, coming out antero-posteriorly, and shutting off a cell in the roof of the orbit, which might be termed the anterior ethmoidal cell, pure and simple. In both of them the dependent point was downwards and into the infundibulum, and if one removed the anterior end of the

middle turbinal and opened up the ethmoidal labyrinth with punch forceps from the interior of the nose there would be drainage into the nasal cavity ; if there were granulations coming down from the frontal sinus and other cells in that region, and one wished to remove them by scraping or any other radical measure, it would, of course, be necessary to operate from the front. He maintained that those cells, by appropriate treatment, opening up from the interior of the nose, would drain into the nose, and one could wash out the cavities and use instillations in a manner which would prove satisfactory in most cases.

Dr. W. HILL asked why the current name "fronto-ethmoidal cell" should not be applied to what Dr. Thomson called "ethmoidal-orbital"? A fronto-ethmoidal cell did not normally communicate with the frontal sinus. He maintained that those indicated were the genuine fronto-ethmoidal cells which one opened every time one performed a radical operation for frontal sinusitis. Moreover, the cells could be seen opening at the typical place in the nose. The ethmoidal part of the cell was rather small, and the frontal part was very well developed in the specimens shown.

Dr. LAMBERT LACK said he thought the practical point had been rather overlooked. After the anterior ethmoidal cells had been opened up as freely as possible, if there was still pus coming down from the anterior ethmoidal region one would probably diagnose suppuration in the frontal sinus, proceed to do a radical frontal sinus operation, and then those cells would be opened. It did not matter whether it was an ethmoidal cell or the frontal sinus ; if it was diseased, obviously an external and extensive operation would be necessary, as if it were a frontal sinus. The occasional presence of such a cell was no argument against attempting to operate on the ethmoidal cells from the nose.

Dr. HERBERT TILLEY agreed with Dr. Lack. Yesterday afternoon he had an illustration of his contention in a patient who had had four operations done on the frontal sinus, but there was still two suppurating fistulae, which came out above and below Killian's bridge. Yesterday he opened up the sinus, and the whole trouble was discovered at the back of the sinus, where there was a small suppurating cell extending backwards nearly to the small wings of the sphenoid. It had infected the floor of the sinus, and it could not have been reached from the nose—it was too lateralised. He could only deal with it by taking away its lower wall, so as to expose the roof of the orbit, and let the orbital tissues rise into it. That was really the essence of Killian's operation. The fronto-ethmoidal cells, which spread outwards or backwards through the roof of the orbit, would infect the most complete operation one could do on the frontal sinus, and such cases could not be cured, and got dry unless those cells were obliterated.

Dr. PATERSON said the cells in question were part of the frontal sinus. It was the orbital recess which was often partially shut off by thin septa from the main part of the sinus, and in both those specimens the septa were rather imperfect. It was described in Killian's atlas as the orbital recess of the frontal sinus. He knew the recess from practical experience, because in very extensive operations which he had to do in connection with the sinus it was found very large, and it was necessary to strip off the periosteum from the plate of the orbit before getting to the bottom of it. He did not think it would be necessary to excise the eyeball to get at that part as had been suggested. It meant simply that if one stripped the periosteum from the orbital plate, and held the contents of the orbit aside, one could, with Hartmann's conchotome, get at the

deepest part of it. He got at it from below the bridge. He had two cases quite recently which he had so treated with excellent results, and which amply confirmed Dr. Thomson's contention.

Dr. STCLAIR THOMSON, in reply, said there was a risk in working from below, because of the liability to push upon the eye; and he had heard of a bad result from that in Berlin. It did not matter whether the space was called "fronto-ethmoidal," or "ethmoido-frontal," or "frontal recess." He used the term "orbital-ethmoidal" to indicate that it ran over the orbit. Dr. Westmacott rather questioned whether it should be treated surgically, but that subject must be left for another day. He brought the skulls forward to show that if the frontal sinus and its accessories were to be treated surgically he saw no means of getting at it except by the complete Killian, without the so-called modification of it in any way. He thought the most important cause of disasters in the past was the overlooking of those cells, where suppuration got cut off.

SPECIMEN OF DEGENERATED ETHMOIDS REMOVED FROM A CASE OF MULTI-SINUSITIS.

Shown by Dr. STCLAIR THOMSON. This specimen consisted of the degenerated ethmoid, and, when freed of all blood and liquid at the time of operation, weighed exactly 4 oz. There had been complete obstruction of the nostrils.

CASE OF ADHERENT SOFT PALATE AFTER OPERATION FOR ITS SEPARATION.

Shown by Mr. H. BETHAM ROBINSON. A boy, aged seventeen, came to St. Thomas's Hospital in September, 1906, with complete adhesion of his soft palate to the posterior pharyngeal wall, no nasal respiration, and absolute deafness. Since early life he had been deaf, and had been troubled with accumulation of mucus in the nasal cavities. He had had the "blight" in his eyes, and now he shows slight corneal opacities due to old keratitis. He had had also discharge from his ears, and the right drum was cicatricial, and the left one had a large perforation. His teeth are bad, but they give no distinctive evidence of congenital syphilis. Congenital syphilis was, however, regarded as the cause of the adherent palate. His condition was so wretched that I determined to give him relief by separating his soft palate.

On October 13 I separated the palate from the pharynx freely from side to side; at its attachment it was a full quarter of an inch thick. The freed palate was prevented from again uniting in the following manner. A piece of lead plate was cut the full breadth of the naso-pharynx, and it was bent so that one arm of it rested on the dorsal surface of the soft palate and the lower on the buccal surface, the cut margin being received between the plates and apposed to the bend, and so kept away from the pharyngeal

wall. Silk threads were fixed to the four corners of the piece of lead; the two from the upper corners passed one through each nostril, and the lower two passed forward across the hard palate between the lateral and central incisors on each side. The upper and lower threads on each side were then tied together in front over the lip, but they were prevented from cutting by being passed through pieces of rubber tubing. After the first day he had comparatively little trouble, being able to swallow fluids and other soft food without any special complaint. Aristol was blown into the nose and over the palate surface daily. The lead plate was not removed for a fortnight, by which time it was considered sufficient healing would have taken place to prevent re-union. Bearing in mind the almost certain specific origin of the mischief he was put on iodide of potash directly after operation to hasten the healing. At the end of eight months there is not the slightest contraction. By Politzerisation and passing the catheter his hearing has been restored to almost normal, and he is able to breathe freely through his nose. To sum up: the lad, by the operation, has become quite bright and intelligent instead of a worry to his relatives from his previous helpless state.

Mr. TILLEY congratulated Mr. Robinson on an excellent result in a very intractable class of case.

Dr. LIEVEN said it was a very good result, but it was necessary to be very careful in those cases. This one was successful because the adhesion was horizontal and was very thick, a slit thus resulting. In many of those cases of adhesion there was atrophy of the velum. Therefore in operating the hole sometimes got too large and the patient might be worse off than he was before, because from that moment they could not eat and drink properly, food and liquid getting into the nose. He had had such a patient, who told him he was much worse after the operation for that reason. There was always the chance that the hearing might be improved if the patient was not too old. It was a very clever idea to pass strings afterwards through the nose. He had heard the same idea spoken of by Professor Hopmann, of Cologne, who used to put india-rubber strings through the nose to hold the velum forwards so that he could get at the naso-pharynx. But he doubted whether a nervous patient would stand those strings for a fortnight. He recommended the use of a little instrument which he brought forward fourteen years ago, an indiarubber tube which led into a ball of the same material. It was put into the nose by a Belloc sound, and the patient himself filled it with air when the ball had arrived at the naso-pharynx, and that exerted active pressure against the cicatricial contraction. It mostly worked in the direction of least resistance, *i.e.* towards the opening which the operator had made. If that were put in at the beginning twice every day for a few hours, and applied less and less as time went on, there would be a very good result.

Mr. ATWOOD THORNE asked how long it was since the operation was done, and how long the appliance was kept in.

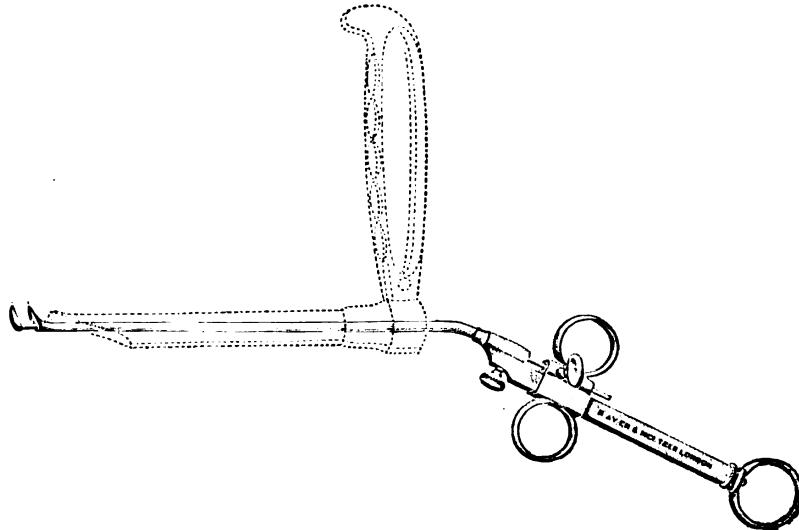
Mr. ROBINSON, in reply, said the operation was done on October 13 last, so he thought it had stood the test of time. The appliance was kept in for a fortnight.

LARYNGEAL FORCEPS FOR USE IN DIRECT LARYNGOSCOPY.

Shown by Dr. STCLAIR THOMSON. These forceps are made with several extremities, which can be attached to the one barrel. The handle is well out of the way and allows of clear vision.

FORCEPS FOR THE REMOVAL OF NEW GROWTHS AND THE EXTRACTION OF FOREIGN BODIES FROM THE LARYNX AND ADJACENT PARTS BY THE DIRECT METHOD.

Shown by Dr. JOBSON HORNE. The instrument is constructed on the rod and cannula principle, the blades closing by traction and not by a joint. It is intended for use, as shown in the drawing, through a tubular spatula. The shaft is placed at an angle to the



handle. The blades are also placed at an angle to the rod, and are made sharp, blunt, or serrated, to meet the requirements of the case, whether it be a growth or a foreign body to be removed, some operators preferring blunt before sharp instruments for removing laryngeal growths of a pedunculated nature. The cannula can be rotated and fixed in any position. The advantages claimed for the forceps are :

- (1) That it occupies the minimum amount of space within the tubular spatula and the field of operation ; the line of vision is not obstructed by the instrument used.



I. EPITHELIOMA OF THE LARYNX.

Photograph of the posterior aspect of a larynx removed by complete laryngectomy.

To illustrate a communication to the Laryngological Society of London,
June 7, 1907, by Dr. JOBSON HORNE.



II. EPITHELIOMA OF THE LARYNX.

Photograph of the posterior aspect of a larynx removed by complete laryngectomy.

To illustrate a communication to the Laryngological Society of London,
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(2) The closing of the blades, by traction gets rid of the "kick" occasioned by a forceps closing on the hinge or joint principle.

(3) The small spoon-shaped blades, by being placed at an angle instead of in the same straight line, can be insinuated by the side of foreign bodies and into all parts of the larynx. This is particularly advantageous in removing growths from the anterior commissure and recesses of the ventricles.

The instrument has been made for me by Messrs. Mayer and Meltzer, of Great Portland Street, London.

Dr. PATERSON thought the forceps exhibited were exceedingly useful. There was one used by Edmund Meyer, of Berlin, which closely resembled that shown by Dr. StClair Thomson, and he himself had used it from time to time. On the whole he found his own forceps very adaptable, and, perhaps, more powerful than either of those shown that day.

EPITHELIOMA OF THE LARYNX.

Dr. JOBSON HORNE exhibited two macroscopic specimens of epithelioma of the larynx from patients who had undergone complete laryngectomy. For the specimens he was indebted to Mr. F. G. Harvey, who, as members of the Society knew, was one of the pioneers in the further development of the operation. The operations were performed by Mr. Harvey, at the Throat Hospital, Golden Square, as far back as 1901. In one case the patient was known to be living twelve months after the operation, whilst, in the other case, the patient, after recovering from the operation, died within that period of time. Some account of the first case will be found in the series of cases reported by Mr. Harvey to the *Lancet* in 1901. Dr. Jobson Horne exhibited the preparations—which showed the larynx in each case entire, and the colouring preserved by the formalin method—as instructive pathological specimens illustrating the stage of the disease in which complete laryngectomy is the only operation admissible.

A CASE OF NÆVUS OF THE TONGUE.

Shown by Mr. STUART-Low. He said that he had shown this case because it was unusual to find such a large nævus of the tongue in such a young patient. The girl was now twelve years of age, and being an orphan, had been in the same institution since she was three years old. The nævus was situated on the right side of the tongue on the anterior third; it was now the size of a florin, but at the age of three it was only as large as a bean.

It was said to have grown rapidly during the last year. Mr. Stuart-Low proposed to incise the whole growth with scissors, and stitch the cut surfaces.

Dr. DAVIS thought electrolysis would cure it.

A CASE OF CHRONIC FRONTAL SINUS DISEASE.

Shown by Mr. STUART-LOW. He said that this young woman was operated upon by him one month ago that day for chronic frontal sinus disease. The disease had existed for quite seven years, and during the past year she had suffered severely from frontal headache and had had much nasal discharge. Having opened the sinus it was discovered to be quite full of mucous polypi, and the partition between the two sides having been partially removed, the opposite sinus was found in a similar condition. It was found necessary to remove a considerable portion of the anterior bony wall of the sinus, and to obviate the deformity usual after this from falling in of the soft structure, Mr. Stuart-Low had inserted a thin, perforated, silver plate over the opening in the bone. The wound was douched with fresh lamb's blood serum, as explained in an article in the *Lancet* on May 7, 1907, which seemed to facilitate the healing process, and a protective shield worn to avoid bandage pressure. The wound healed by first intention, and the silver plate had remained in position well and so prevented any blemish from sinking in of the skin. The patient was only four days in the hospital, and now expressed herself as free from pain and offensive nasal discharge.

TUMOUR OF THE PHARYNGO-GLOSSUS, NOT MALIGNANT; POSSIBLY OF THE NATURE OF A DERMOID OR ACCESSORY THYROID.

Shown by Dr. DUNDAS GRANT. A female patient, aged twenty-three, complains of difficulty of speaking and swallowing which has been marked for one year, although it had been gradually developing for about five years. Her voice has the characteristic thickness associated with pharyngeal obstruction. The pharyngeal portion of the tongue is almost entirely occupied by a rounded swelling of comparatively smooth surface and red tint, and with vascular ramifications under the mucous membrane. It is elastic to the feel as if cystic in nature and there are no enlarged glands. It has not been punctured or incised. It is more probably thyroid than dermoid in view of its projection into the pharynx instead of into the sub-maxillary region. The exhibitor considers it non-

malignant and hopes to be able to extirpate it through the mouth, but will be guided by the degree of accessibility as attained under an anaesthetic.

Mr. CRESSWELL BABER said it reminded him of a case which he showed some time ago, of thyroid tumour at the base of the tongue (*Proceedings* of this Society, vol. ii, p. 1). In his case the tumour was about the size of a walnut, and it was removed with the galvano-cautery snare. It also occurred in a young woman.

Mr. WESTMACOTT said it appeared to be of the nature of a retention cyst in the thyro-glossal duct. Ten years ago he went through all the recorded cases of that character, but in none of the cases which he looked up was there any dermoid tissue found in the thyro-glossal duct of His.

SOFTENING GUMMA ON EXTERNAL SURFACE OF LEFT ALA NASI.

Shown by **Mr. HERBERT TILLEY**. Patient is a male, aged twenty-five, who had syphilis five years ago. The left side of the nose has increased in size during the past four weeks and produced considerable external deformity. At the present moment almost the whole extent of the left side of the nose is occupied by a red, oedematous, semi-fluctuating, tender swelling the size of half a walnut. No intra-nasal swelling can be seen in the left nasal cavity, neither is the septum deflected to the right in its upper portions. The patient has been put on full doses of iodide of potash.

ANNUAL MEETING

Held Friday, June 7, 1907, at 4 p.m., at 20, Hanover Square.

J. B. BALL, M.D., President, in the Chair.

HENRY J. DAVIS, M.B., } Hon. Secretaries.
W. JOBSON HORNE, M.D., }

The minutes of the last Annual Meeting were read and confirmed.
The Report of the Council was then read and unanimously adopted.

REPORT OF THE COUNCIL FOR THE YEAR ENDING JUNE 7, 1907.

The session now closing has been one of unusual prosperity. The important and instructive communications made to the Society have been almost too numerous to permit of all receiving the attentions they deserved.

The meetings have been well attended—the average attendance of 38 being above that of previous years, if not the largest on record. We have been honoured by many distinguished visitors from amongst our foreign and British *confrères*.

We deeply regret to record the loss to the Society, through death, of **Mr. R. W. Stewart**, for some years its treasurer, Dr. Willcocks, a vice-president, and Dr. G. Schorstein.

During the past session one honorary and nine ordinary members have been elected.

Congratulatory addresses were forwarded by the Society to Professor Fraenkel, of Berlin, and Professor Schroetter, of Vienna, on the occasion of their respective celebrations, and it has given pleasure to learn of the gratification these addresses afforded to the recipients.

The Council has given full consideration to matters connected with the amalgamation scheme, and, in conjunction with the Council of the British Laryngological, Rhinological, and Otological Association, it has arranged the details to the satisfaction of all concerned.

Since the foundation of the Society in February, 1893, 115 ordinary meetings have been held. The number of original members was 45. The Society now consists of 151 ordinary members and 12 honorary members.

It has contributed to medical literature a series of *Transactions*, which will be ever of value to those engaged in the study and research of medical science.

The Society, full of vigour and increasing strength, now ceases to exist as the Laryngological Society of London, in accordance with a resolution which will be submitted to you to-day. In its place the Section of Laryngology of the Royal Society of Medicine will be formed. We hope, and we fully expect, that the Section of Laryngology will carry on the traditions of this Society, and that under the new conditions we shall flourish and prosper even more than in the past.

The Honorary Treasurer's Report was read and unanimously adopted.

BALANCE SHEET.—SESSION 1906-7.

DR.	£ s. d.	CR.	£ s. d.
Balance, June, 1906 . . .	83 18 2	Rent	42 0 0
Subscriptions, 1904-5 . . .	2 2 0	Electric Lighting (Garcia	
" 1905-6 . . .	29 8 0	Celebration)	1 10 0
" 1906-7 . . .	137 11 4	Reporting	20 8 6
Entrance Fees	11 11 0	Indexing Reports	2 0 0
Sale of <i>Transactions</i> . . .	1 8 6	Bale and Danielsson	3 3 0
Interest on Deposit	6 1 6	Pulman	1 16 0
		Adlard	73 10 11
		Typewriting	2 8 4
		Library Supply Co. . . .	0 2 4
		Annual Dinner	7 14 0
		Baker—Microscopes	0 17 0
		Martindale	0 12 0
		Rogers	0 13 6
		Methylated spirit	0 1 6
		Mathew (porter)	2 0 0
		Porter's Xmas Boxes	2 0 0
		Secretaries' Expenses	3 10 0
		Treasurer's Expenses	1 7 8
		Bank Charges	1 1 6
		Balance	105 4 3
	<hr/> £272 0 6		<hr/> £272 0 6
Amount on Deposit at Bank	150 0 0		
Balance at Bank	105 4 3		
Total to Society's credit	<hr/> £255 4 3		

June, 1907.

H. BETHAM ROBINSON, *Hon. Treasurer.*

The Honorary Librarian's Report was unanimously adopted.

LIBRARIAN'S REPORT.

During the past year our Library has been made fair use of, and most of our exchanges have been maintained. Having a good stock of back numbers I have been able to meet several applications for our *Proceedings*. One gentleman in Paris bought a complete set of four volumes, and I have been able to hand over to the Treasurer a cheque for £1 8s. 6d., as a result of sales effected.

I might remind members that we possess a complete card index, and also a complete set of bound volumes of the *Transactions*.

During the past year the following donations have been made to the Library:

Presented by Dr. F. de Havilland Hall.

1. Krankheits und Behandlungslehre der Nasen-, Mund- und Rachenöhle sowie des Kehlkopfes und der Luftröhre, von Maximilian Bresgen. 2te Aufl. Wien und Leipzig, 1891.
2. Die Heilbarkeit der Larynxphthise und ihre chirurgische Behandlung, von Theodor Heryng. Stuttgart, 1887.
3. Studies from the Saranac Laboratory for the Study of Tuberculosis. (E. L. Trudeau, M.D., Director.) Boston, 1900-1904.
4. Herr Grossmann und die Frage der Posticuslähmung, von Sir Felix Semon. (Sonder-Abdruck aus dem Archiv für Laryngologie, 6 Bd., 3 Heft.) Berlin, 1897.
5. Étiologie et traitement de certains troubles vocaux. (Extrait de La Parole, No. 5, 1899.) Par Paul Olivier. Paris, 1899.
6. Épistaxis spontanées (a répétition). Relation de cinq cas. (Extrait de La Parole, No. 8, 1899.) Par Marcel Natier. Paris, 1899.
7. Sulle vegetazioni adenoidi in generale e più particolarmente sui loro rapporti colle otopatie. (Estratto dalla Clinica Moderna, Anno X, n° 4, 5, 6, 7. Per Vittorio Grazzi. Firenze, 1904.
8. Sputum Examination in Pulmonary Tuberculosis and its Prognostic Value. (Repr. from the Montreal Medical Journal, October, 1901.) By Lawrason Brown.
9. Über Nasensteine im Anschluss au zwei neue Fälle. Inaugural-Dissertation, von Max Seeligmann. Karlsruhe, 1892.
10. Corps étrangers des bronches et bronchoscopie. Par E. J. Moure. Bordeaux, 1906.
11. An Analysis of Fifteen Hundred Cases of Tuberculosis discharged from the Adirondack Cottage Sanatorium from Two to Eighteen Years Ago. (Repr. from the Journal of the American Medical Association, Nov. 21, 1903.) By Lawrason Brown. Chicago, 1903.
12. Autoscopy of the Larynx and the Trachea. (Examination without laryngeal mirror.) By Alfred Kirstein.
13. Third Annual Report of the Reception Cottage, Saranac Lake, New York. April, 1904.

Presented by the Author.

14. De behandeling der secundaire ontsteking van het oor-labyrinth. (Overgedrukt nit het Nederl. Tijdschrift voor Geneeskunde, 1906, Tweede Helfte, No. 3.) Door H. Burger.
15. Een kunstmatige dermoidkyste. (Overgedrukt nit het Nederl. Tijdschrift voor Geneeskunde, 1906, Tweede Helfte, No. 4.) Door H. Burger.
16. De kwakzalverij in de oorheelkunde. (Overdruk nit het gedenkboek, nitgegeven ter gelegenheid van het vijf-en-twintigjarig bestaan der vereeniging tegen de kwakzalverij.) Door H. Burger.

Presented by H. Burger.

17. Nederlandsche Keel- Nous- en Oorheelkundige Vereeniging, Jaarvergadering, Zaterdag, 28, en Zondag, 29 October, 1905, in het Physiologisch Laboratorium te Utrecht.

Presented by the Society.

18. Nederlandische Gesellschaft für Hals-, Nasen- und Ohrenheilkunde. XIV Versammlung in Utrecht am 28 und 29 Oktober, 1905, im Physiologischen Laboratorium. (Aus der Monatsschr. für Ohrenheilkunde, 1906, Heft 6.)

The Honorary Curator's Report was read and unanimously adopted.

CURATOR'S REPORT.

Our thanks are due to the members whose names are to be found in the following list, for some forty odd microscopical sections that have been contributed to the collection since my last report in January, 1906. Of those in the supplementary catalogue, I hope many will find their way into that referring to our Proceedings by being exhibited with their clinical histories next session. The majority of the new sections are of unusual interest, but there are a few that are of so much importance that I propose to call special attention to them.

In the *nose and accessory cavities* class we have a good example of the peculiar spiral and knotted threads found in a mucous polypus, and shown by Dr. Hugo Löwy, and a very instructive specimen of lupus of the triangular cartilage, including the cartilage and sub-mucous tissues contributed by Dr. Furniss Potter. The bleeding polypus collection has been augmented by five additional specimens, viz., from Dr. W. H. Kelson, Dr. Hugo Löwy, Dr. Lambert Lack, Mr. C. A. Parker, and myself (exclusive of Dr. H. B. Robinson's, included in the supplement last year). In the *naso-pharynx* section, we have examples of Dr. Fitzgerald Powell's lymphoid tissue mass with giant-cell formation, and a very typical endothelioma of Mr. Stuart-Low's. In the *oro-pharynx* class there are three allied specimens of the peculiar infiltration of that region (as seen in the *uvula*) described by Sir Felix Semon, one contributed by himself, and two by Dr. Brown Kelly; we also have the two sections from a case of spheroidal cell carcinoma respectively before and after *neoformans* inoculation, shown by Dr. Scanes Spicer. The *larynx* collection is enriched by two examples of keratosis of the vocal cords, from Dr. Logan Turner and Dr. Scanes Spicer, the one completing the histological picture and confirming the diagnosis of the other. In conclusion, I may express a hope that the new phase which we are about to enter will not interrupt the expansion of this magnificent collection. It is a lasting record of the histology of numbers of cases that have passed from observation, and a safe harbour for otherwise scattered specimens in danger of destruction.

A. CATALOGUE REFERRING TO *Proceedings*.

I. *Nose and Accessory Cavities*.

1. Bleeding Polypus of Septum (Vascular type of Fibro-angioma), Dr. H. B. Robinson, March, 1906, vol. xiii, p. 68.
2. Bleeding Polypus of Inferior Meatus, March, 1906, vol. xiii, p. 72, Dr. W. H. Kelson and Dr. Pegler.
3. Lupus (Tuberculoma) of Septum, including Basal Cartilage, February, 1907, vol. xiv, p. 43, Dr. Furniss Potter.
4. Nasal Polypus, exhibiting Spiral Mucous Threads, March, 1907, vol. xiv, p. 55.

II. *Naso-pharynx*.

1. Angeio-fibroma, January, 1906, vol. xiii, p. 40, Dr. E. A. Peters.
2. Squamous (Malpighian) Cell Carcinoma, February, 1906, vol. xiii. p. 51, Mr. Stuart Low.

3. Lymphoid Tissue Tumour with Giant Cell Formation, May, 1907, vol. xiv, p. 91, Dr. Fitzgerald Powell.
4. The same case stained for tubercle bacilli.
5. Polypoid growth from same case.

III. Mouth, Tongue, Palate.

1. Lardaceous-looking, variable Infiltration of Uvula, February, 1903, vol. x, p. 11, Sir Felix Semon.
2. Sclerotic Hyperplasia of Uvula, December, 1905, vol. xiii, p. 20, Dr. A. Brown Kelly.
3. Papilloma of Uvula, December, 1905, vol. xiii, p. 22, Dr. E. A. Peters.
4. Hyperplastic Congenital Syphilis of Uvula, March, 1906, vol. xiii, p. 68, Dr. A. Brown Kelly.
5. Endothelioma of Soft Palate, February, 1907, vol. 14, p. 44, Mr. Stuart Low.

IV. Pharynx.

1. Squamous Cell Carcinoma, April, 1906, vol. xiii, p. 88, Mr. H. W. Carson.
2. Spheroidal Cell Carcinoma ("Hunt"), June, 1906, vol. xiii, p. 105, Dr. Scanes Spicer.
3. Spheroidal Cell Carcinoma, same case after injection with bacterial vaccine of *Micrococcus neoformans*, November, 1906, vol. xiv, p. 8, Dr. Scanes Spicer.
4. Squamous Cell Carcinoma, May, 1907, vol. xiv, p. 94, Dr. Dundas Grant.

V. Larynx.

1. Multiple Papilloma of Larynx ("Howard"), November, 1905, vol. xiii, p. 12, Dr. Scanes Spicer.
2. Keratosis of Vocal Cords (Dr. Scanes Spicer), February, 1906, vol. xiii, p. 50.
3. Keratosis of Larynx, April, 1906, vol. xiii, p. 82, Dr. Logan Turner.
4. Squamous Cell Carcinoma in Arytænoid Region, April, 1906, vol. xiii, p. 88, Mr. H. W. Carson.
5. Carcinoma of Arytænoid Region, November and December, 1906, vol. xiv, pp. 11 and 26, and January, 1907, vol. xiv, p. 36, Dr. Watson Williams and Dr. Scanes Spicer.
6. Squamous Cell (Scirrhous) Carcinoma of Vocal Cords, May, 1907, vol. xiv, p. 95, Dr. Lambert Lack.

B. SUPPLEMENTARY CATALOGUE.

I. Nose and Accessory Cavities.

1. Inflammatory Growth from Middle Turbinate, Dr. Wm. Milligan.
2. Inflammatory Growth from Septum, Dr. Wm. Milligan.
3. Cyst of Middle Turbinate, Dr. Lambert Lack.
4. Early Stage of Atrophic Rhinitis, Dr. Lambert Lack.
5. Bleeding Polypus of Septum (Cellular Type of Fibro-angioma), Dr. Hugo Löwy.
6. Bleeding Polypus of Septum (similar type to No. 5), Dr. Pegler.
7. Bleeding Polypus of Septum (Angeio-fibroma Type), Mr. C. A. Parker.
8. Bleeding Polypus of Septum (Edematous Fibro-angioma type), Dr. Lambert Lack.
9. Squamous Cell Carcinoma (Polypoid Growth) of Nose and Maxillary Antrum, Dr. Wyatt Wingrave.
10. Squamous Cell Carcinoma (Polypoid Growth), Dr. Pegler.

II. Naso-Pharynx.

1. Naso-pharyngeal Mucous Polypus, Dr. Scanes Spicer.

III. Mouth, Tongue, and Palate.

1. Lymphangioma of Lower Lip. Dr. Pegler.

IV. Pharynx.

1. Polypoid Fibroma of Anterior Pillar, Dr. Alfred Brown.
2. Squamous Cell Carcinoma of Anterior Pillar with Giant Cells, Dr. E. A. Peters.

V. Larynx.

1. Squamous (Prickle) Cell Carcinoma of Vocal Cords from Case of Thyrotomy, Dr. Pegler.
2. Myxomatous Fibroma of Vocal Cord, Dr. G. A. Cathecart.
3. Interarytænoid Hypertrophy, Dr. Lambert Lack.

SPECIAL MEETING.

A Special Meeting of the Society was held immediately after the Annual Meeting, for the purpose of submitting the following Resolutions, which were unanimously adopted :

1. *Resolved* : "That, in pursuance of the decision of this Society to unite with other Societies in forming the Royal Society of Medicine, which has now been granted a Royal Charter from His Majesty the King, all the property of every kind whatsoever of this Society be and is hereby transferred to the Royal Society of Medicine, and the Treasurer is hereby directed forthwith to transfer to the Royal Society of Medicine all sums of money in his possession, standing in his name, or at the credit of the Society at its bank."
2. *Resolved* : "That the Laryngological Society of London be discontinued, and is hereby dissolved."

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CATALOGUE
OF
MICROSCOPICAL SPECIMENS IN
THE CABINET
OF THE
LARYNGOLOGICAL SOCIETY OF LONDON

INCORPORATED, IN 1907, WITH THE ROYAL SOCIETY OF MEDICINE

COMPILED BY
L. H. PEGLER, M.D.,
HONORARY CURATOR,

(*By request of the Council.*)

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NOTE BY THE COMPILER.

THE Catalogue consists of two parts :

(1) The "A" or Reference Part, containing a list of microscopical preparations associated with the 'Proceedings' of the Laryngological Society of London during its entire existence, and constituting as complete a record as the generosity of the contributors or the preservation of the specimens by the latter after exhibition, has permitted.

(2) The "B" or Supplementary Part, comprising micro-sections also voluntarily contributed and bearing equally on the Pathology of Diseases of the Nose and Throat, but with a few exceptions, not referred to in the Society's 'Proceedings.' Such exceptions having been exhibited as "Card" Specimens with neither patient nor clinical history, have failed to comply with the object in view when the Collection was commenced, viz., the association of Pathology with Clinical observation.

The numbering of the Specimens in each of the five subdivisions of the Reference Catalogue having been chronological from its inception, this order is maintained, but that in the Supplementary Catalogue is structural and pathological.

Both lists are virtually a compendium of the Curator's reports since their commencement in January, 1900, but few corrections having been found necessary in course of revision. In the "A" Catalogue, all references to the Morbid Growths' Committee's Reports are stated, and when a specimen relates to a case that has been exhibited more than once before the Society, the reference to the date (with volume and page) when the specimen was shown, takes precedence.

An Index to the contributors with the catalogued numbers of their specimens is appended.

HARLEY STREET;
December, 1907.

PART A.

REFERENCE CATALOGUE OF MICROSCOPICAL SECTIONS.

I. NOSE AND ACCESSORY CAVITIES.

1. P. de Santi. Papilloma of Septum Nasi. Vol. ii, p. 13, November, 1894.
2. E. Cresswell Baber. Papillomatous Growth from Floor of Nose and Septum. Vol. ii, p. 63, April, 1895.
3. William Hill. Inferior Turbinal, Re-growth of Mucous Tissue after Turbinectomy. Vol. iii, pp. 15, 42, November, 1895; April, 1905.
4. William Hill (**M. G. C. R.**,* vol. iii, p. 83). Tuberculosis of Inferior Turbinal (Lupus). Vol. iii, p. 70, March, 1896.
5. J. W. Bond (**M. G. C. R.**, vol. iv, p. 40). Papillary Carcinoma (or Sarcoma?) of Septum. Vol. iv, p. 4, November, 1896.
6. P. McBride (**M. G. C. R.**, vol. iv, p. 40). Destructive Ulceration of the Nose and Face. Vol. iv, p. 18, December, 1896.
7. Logan Turner (**M. G. C. R.**, vol. iv, p. 40). Papilloma of Septum Nasi (Cauliflower Growth). Vol. iv, p. 21, December, 1896.
8. F. W. Bennett. Tuberculosis of Inferior Turbinal (Lupus). Vol. iv, pp. 43 and 82, January and April, 1897.
9. L. H. Pegler. Inferior Turbinal, complete Re-growth of Mucous Tissue after Removal. Vol. iv, p. 75, April, 1897.
10. L. H. Pegler. Bilateral Lymphoid-tissue Tumours of Septum Nasi. Vol. v, p. 16, December, 1897.
11. R. H. Scanes Spicer (**M. G. C. R.**, vol. v, p. 42). Fibro-angioma of Septum ("Bleeding Polypus"). Vol. v, p. 19, December, 1897.
12. McLeod Yearsley. Papilloma of Septum Nasi. Vol. v, p. 78, April, 1898.
13. Arthur Cheatle. Hypertrophy of Tuberculum Septi. Vol. vi, p. 6, November, 1898.
14. E. Cresswell Baber (**M. G. C. R.**, vol. vii, p. 55). Papilloma from Right Choana Nasi. Vol. vi, p. 109, June, 1899.
15. Dundas Grant. Rhino-scleroma from the Vestibule. Vol. vii, p. 85, April, 1900.
16. Dundas Grant. Squamous-cell Carcinoma of Nose, Antrum, Orbit, etc. Vol. viii, p. 7, November, 1900.
17. Wyatt Wingrave. Papilloma of Septum Nasi (Vestibular). Vol. viii, p. 3, April, 1901.
18. E. B. Waggett. Myeloma of Middle Turbinal Region and Antrum. Vol. ix, p. 62, February, 1902.

* Morbid Growths Committee's Report in 'Proceedings.'

19. L. H. Pegler (**M. G. C. R.**, vol. ix, p. 114). Cystic Tumour from Middle Meatus (simulating Meningocele). Vol. ix, p. 103, April, 1902.
20. Dundas Grant (**M. G. C. R.**, vol. ix, p. 113; vol. x, p. 64). Columnar Cell Carcinoma of Nose and Maxillary Antrum. Vol. ix, p. 108, April, 1902.
21. Richard Lake (**M. G. C. R.**, vol. x, p. 97). Round-cell Sarcoma of Right Inferior Turbinal. Vol. x, p. 52, January, 1903.
22. Richard Lake. Carcinoma following Lupus of Inferior Turbinal. Vol. x, p. 52, January, 1903.
23. A. Brown Kelly (Case 1). Fibro-angioma of Septum (Bleeding Polypus). Vol. x, p. 66, February, 1903.
24. A. Brown Kelly (Case 2). Fibro-angioma of Septum (Bleeding Polypus). Vol. x, p. 66, February, 1903.
25. A. Brown Kelly (Case 3). Fibro-angioma from Ala Nasi, Vestibular surface. Vol. x, p. 66, February, 1903.
26. A. Brown Kelly (Case 4). Granulomatous Polypus from Septum Nasi. Vol. x, p. 66, February, 1903.
27. Hunter Tod (**M. G. C. R.**, vol. x, p. 98). Fibro-angioma of Septum (Bleeding Polypus). Vol. x, p. 72, February, 1903.
28. W. H. Kelson. Mucous Polypus containing Giant Cells. Vol. x, p. 80, March, 1903.
29. E. Cresswell Baber. Fibro-angioma from Ala Nasi, Vestibular surface. Vol. x, p. 85, March, 1903.
30. F. O'Kinealy, Major I.M.S. Psorospermosis of Septum (Rhinosporidium Kinealyi). Vol. x, p. 109, April, 1903; also vol. xi, p. 43.
31. E. B. Waggett (**M. G. C. R.**, vol. xii, p. 32). Primary Tuberculous Ulcer of Septum. Vol. x, p. 125, May, 1903.
32. L. H. Pegler. Gumma of Septum Nasi. Vol. x, p. 137, June, 1903.
33. Eugene Yonge. Middle Turbinal; early Polypus formation. Vol. xi, p. 107, February, 1904.
34. H. Lambert Lack. Carcinoma of Maxillary Antrum (C. cylindromatosum, Ziegler), vol. xi, p. 111, February, 1904.
35. Adolph Bronner. Soft Fibro-angioma from Maxillary Antrum. Vol. xi, p. 164, May, 1904.
36. R. H. Scanes Spicer (**M. G. C. R.**, vol. xii, p. 32). Fibro-angioma of Septum (Bleeding Polypus). Vol. xi, p. 164, May, 1904.
37. R. H. Scanes Spicer (**M. G. C. R.**, vol. xii, p. 32). Inflammatory Polypoid Growth from Maxillary Antrum and Ethmoid. Vol. xi, p. 165, May, 1904.
38. Henry Smurthwaite. Primary Tuberculosis of Septum Nasi. (Lupus?) Vol. xi, p. 184, June, 1904.
39. P. McBride (**M. G. C. R.**, vol. xii, p. 32). Cystic Polypus from wall of Middle Meatus. Vol. xi, p. 184, June, 1904.
40. Sir F. Semon. Papillary Columnar-cell Carcinoma. Vol. xi, p. 188, June, 1904.
41. H. Lambert Lack. Bony Tumour of the Ethmoid. Vol. xii, p. 17, December, 1904.
42. Atwood Thorne. Squamous-cell Carcinoma. Vol. xii, p. 75, March, 1905.
43. Dundas Grant (**M. G. C. R.**, vol. xiii, p. 15). Fimbriated Columnar-cell Carcinoma of Maxillary Antrum. Vol. xiii, p. 1, November, 1905.
44. P. de Santi (**M. G. C. R.**, vol. xiii, p. 15). Small Round-cell Sarcoma of Septum Nasi. Vol. xiii, p. 9, November, 1905.
45. H. B. Robinson. Fibro-angioma of the Septum (Bleeding Polypus). Vol. xiii, p. 68, March, 1906.

46. L. H. Pegler and W. H. Kelson. Fibro-angioma from Inferior Meatus. Vol. xiii, p. 72, March, 1906; vol. x, p. 81.
 47. E. Furniss Potter. Lupus of Septum (Cartilage of base included). Vol. xiv, p. 43, February, 1903.
 48. Hugo Löwy. Mucous Polypus exhibiting Spiral Threads and Knots. Vol. xiv, p. 55, March, 1907.
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1. Arthur Cheatle. Cyst of Naso-pharynx. Vol. vi, p. 6, November, 1898.
 2. E. B. Waggett. Sarcoma of Naso-pharynx. Vol. vii, p. 11, November, 1899.
 3. L. H. Pegler. Soft Fibro-angioma of Naso-pharynx. Vol. vii, p. 54, January, 1900.
 4. H. Tilley. Angeio-fibroma of Naso-pharynx. Vol. x, p. 19, November, 1902.
 5. Barclay Baron (**M. G. C. R.**, vol. x, p. 63). Columnar-cell Carcinoma. Vol. x, p. 54, January, 1903.
 6. L. H. Pegler and R. Lake (**M. G. C. R.**, vol. x, p. 64; No. 2). Soft Fibro-angioma of Naso-pharynx (recurrence of Dr. Pegler's Case above). Vol. x, p. 52, January, 1903.
 7. Adolph Bronner. Columnar-cell Carcinoma. Vol. x, p. 79, March, 1903.
 8. E. A. Peters. Angeio-fibroma of Naso-pharynx. Vol. xiii, p. 40, January, 1906.
 9. Stuart Low (**M. G. C. R.**, vol. xiii, p. 106). Squamous-cell Carcinoma. Vol. xiii, p. 51, February, 1906.
 10. H. W. Carson. Squamous-cell Carcinoma of Naso-pharynx and Left Posterior Pillar. Vol. xiii, p. 88, April, 1906.
 11. Fitzgerald Powell (**M. G. C. R.**, vol. xiv, p. 97). Lymphoid-tissue Tumour of Naso-pharynx showing Giant-cells. Vol. xiv, p. 91, May, 1907.
 - b. Fitzgerald Powell. Polypoid Growth from same Case.
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III. MOUTH, TONGUE, PALATE, AND UVULA.

1. Morley Agar (**M. G. C. R.**, vol. v, p. 42). Fibroma of the Tongue. Vol. v, p. 4, November, 1897.
2. Hamilton Burt. Squamous-cell Carcinoma of the Tongue. Vol. x, p. 16, November, 1902.
3. Sir F. Semon. Lardaceous Infiltration of the Uvula. Vol. x, p. 11, February, 1903.
4. James Donelan (**M. G. C. R.**, vol. xii, p. 32). Endothelioma of Soft Palate. Vol. xii, p. 172, May, and 185, June, 1904.
5. Scanes Spicer. Squamous-cell Carcinoma of Soft Palate. Vol. xi, p. 167, May, 1904.
6. W. H. Kelson. Fibroma of Tongue. Vol. xii, p. 127, June, 1905.

7. E. A. Peters. Squamous Papilloma of Uvula. Vol. xiii, p. 22, December, 1905.
8. A. Brown Kelley (**M. G. C. R.**, vol. xiii, p. 106). Sclerotic Hyperplasia of Uvula (Lardaceous Infiltration). Vol. xiii, p. 20, December, 1905.
9. A. Brown Kelly. Congenital Syphilitic Hyperplasia of the Uvula. Vol. xiii, p. 68, March, 1906.
10. Stuart Low. Endothelioma of Soft Palate and Wall of Pharynx. Vol. xiv, p. 44, February, 1907.

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1. Wyatt Wingrave. Fibro-angioma of Tonsil. Case 2, vol. v, p. 17, December, 1897.
2. H. Sharman. Papilloma of Left Posterior Pillar of Fauces. Vol. v, p. 86, May, 1898.
3. H. Sharman. Papilloma of Left Tonsil. Vol. v, p. 86, May, 1898.
4. Arthur Cheatle. Fibro-angioma of Supra-tonsillar Fossa. Vol. vi, p. 78, April, 1899.
5. Lambert Lack. Lympho-sarcoma of the Tonsil. Vol. vi, p. 80, April, 1899.
6. E. Furniss Potter. Large Round-cell Sarcoma of Tonsil, Palate, and Fauces. Vol. vii, pp. 72 and 114, March, and May, 1900.
7. Lambert Lack. Carcinoma of Tonsil. Vol. viii, p. 55, January, 1901.
8. McKenzie Johnston. Small Round-cell Sarcoma of Tonsil. Vol. viii, p. 142, June, 1901.
9. William Milligan (**M. G. C. R.**, vol. ix, p. 54). Lipoma of Pharynx. Vol. ix, p. 41, January, 1902.
10. Lambert Lack (**M. G. C. R.**, vol. x, p. 64). Ulcer (? Syphilitic) of Tonsil showing Giant-cells. Vol. x, p. 50, January, 1903.
11. Lambert Lack. Mucous Patch of Tonsil. Vol. x, p. 94, March, 1903.
12. James Donelan (**M. G. C. R.**, vol. xii, p. 32). Squamous-cell Carcinoma of Right Faucial Pillar under Schmidt's Treatment. Vol. xi, p. 59, December, 1903.
13. Arthur Cheatle. Actino-mycosis of Tonsil. Vol. xii, p. 5, November, 1904.
14. F. H. Westmacott. Tuberculous Ulceration of Pharynx. Vol. xii, p. 43, January, 1905; also Vol. x, p. 108, April, 1903.
15. Scanes Spicer. Spheroidal-cell Carcinoma ("Hunt" Case) before Injection. Vol. xiii, p. 105, June, 1906.
16. Scanes Spicer. Spheroidal-cell Carcinoma ("Hunt" Case) after Injection. Vol. xiv, p. 8, November, 1906.
17. Dundas Grant (**M. G. C. R.**, vol. xiv, p. 97). Squamous-cell Carcinoma. Vol. xiv, p. 94, May, 1907.

V. LARYNX.

1. Percy Kidd. Angeioma of Left Vocal Cord. Vol. i, p. 63, January, 1894.
2. W. G. Spencer (**M. G. C. R.**, vol. iv, p. 39). Spheroidal-cell Carcinoma of Left Vocal Cord. Vol. iv, p. 10, November, 1896.
3. W. G. Spencer (**M. G. C. R.**, vol. iv, p. 39). Spheroidal-cell Carcinoma of Cricoid Cartilage ("Carter" Case). Vol. iv, p. 11, November, 1896.
 - a. Ditto. Metastasis in the Neck. Vol. iv, p. 100, June, 1897.
 - b. Ditto. Metastasis in the Lung.
 - c. Ditto. Metastasis in the Liver.
4. I. W. Bond (**M. G. C. R.**, vol. v, p. 42). Spheroidal-cell Carcinoma of Left Ventricular Band. Vol. iv, p. 104, June, 1897.
5. H. Tilley (**M. G. C. R.**, vol. v, p. 54). Tuberculosis of Right Vocal Cord. Vol. v, pp. 9 and 35, November, 1897, and January, 1897.
6. W. G. Spencer (**M. G. C. R.**, vol. v, p. 54 *). Fibro-angeioma from Case of Carcinoma of Epiglottis and base of Tongue. Vol. v, p. 49, February, 1898.
7. W. G. Spencer. Soft Edematous Fibroma of the Arytænoids. Vol. v, p. 77, April, 1898.
8. Professor Massei. Lupus of the Epiglottis. Vol. vi, p. 1, November, 1898.
9. Chas. A. Parker. Angeio-fibroma of Left Vocal Cord. Vol. vi, p. 43, January, 1899.
10. E. Furniss Potter (**M. G. C. R.**, vol. vii, p. 55). Fibro-angeioma of Right Ventricular Band. Vol. vii, p. 1, November, 1899; also Vol. viii, p. 61.
11. W. G. Spencer. Vocal Cord from Syphilitic Stenosis of the Larynx. Vol. vii, p. 62, February, 1900.
12. R. Lake (**M. G. C. R.**, vol. ix, p. 1). Columnar-cell Carcinoma of Left Arytænoid. Vol. vii, p. 71, March, 1900.
13. Dundas Grant. Soft-cell Fibroma from Interior of Thyroid Cartilage. Vol. vii, p. 86, April, 1900.
14. E. B. Waggett. Carcinoma of the Epiglottis. Vol. vii, p. 131, June, 1900.
15. Wyatt Wingrave. Squamous Papilloma from Anterior Commissure and Left Vocal Cord. Vol. viii, p. 11, November, 1900.
16. T. Mark Hovell (**M. G. C. R.**, vol. ix, pp. 1 and 2). Squamous Papilloma of Left Vocal Cord (specimen removed in 1886). Vol. viii, p. 120, May, 1901.
 - a. Ditto. Removed in 1886.
 - b. Ditto. (Removed in 1887).
17. H. Lambert Lack (**M. G. C. R.**, vol. ix, p. 2). Mixed-cell Sarcoma from posterior wall of Cricoid. Vol. viii, pp. 116 and 128, April and May, 1901.
18. H. Lambert Lack. Cyst from Ventricle of the Larynx. Vol. x, p. 51, January, 1903.
19. R. Lake (**M. G. C. R.**, vol. x, p. 98). Tuberculosis of Right Vocal Cord and Left Ventricular Band. Vol. x, p. 64, February, 1903.

* The slide reported on not in the Collection.

20. H. Lambert Lack. (Edematous thickening of Epiglottis and Arytænoid Region (? tuberculous). Vol. x, p. 93, March, 1903 (also vol. ix, p. 69).
21. R. Lake. Squamous (? malignant) Papilloma from Case of Carcinoma of Oesophagus. Vol. x, p. 124, May, 1903.
22. H. Lambert Lack. Thyroid Adenoma from case of Syphilis. Vol. xi, p. 110, February, 1904.
23. Dundas Grant (**M. G. C. R.**, vol. xii, p. 32). Soft-cell Fibroma of Aryepiglottic Fold. Vol. xii, p. 10, November, 1904.
24. Sir F. Semon. Squamous-cell Carcinoma of Right Vocal Cord. Vol. xii, p. 41, January, 1905.
25. P. de Santi (**M. G. C. R.**, vol. xiii, p. 16). Squamous-cell Carcinoma of Left Arytænoid Region and Pharynx. Vol. xii, p. 55, February, 1905 (also pp. 35 and 67, vol. xii).
26. (1 and 2). Sir F. Semon. Soft Fibroma of Larynx and Neck. Vol. xii, p. 71, March, 1905 (also vol. v, p. 64, and vol. xi, p. 193).
27. Harold Barwell. Tuberculous swelling of the Arytænoids. Vol. xii, p. 84 (case 1), March, 1905.
28. Henry Smurthwaite (**M. G. C. R.**, vol. xiii, p. 15). Fragment of Growth from Right Vocal Cord. Vol. xii, p. 129, June, 1905.
29. R. H. Scanes Spicer. Keratosis of Vocal Cords. Vol. xii, p. 135, June, 1905 (also vol. xiii, p. 50).
30. R. H. Scanes Spicer. Multiple Squamous Papilloma of Larynx and Epiglottis ("Howard" Case). Vol. xiii, p. 12, November, 1905.
31. Logan Turner. Keratosis of Vocal Cords. Vol. xiii, p. 82, April, 1906.
32. H. W. Carson. Squamous-cell Carcinoma of Left Arytænoid Region. Vol. xiii, p. 88, April, 1906.
33. R. H. Scanes Spicer and P. Watson Williams. Squamous-cell Carcinoma of Epiglottis and Arytænoid Region ("Search" Case). Vol. xiv, p. 26, January, 1907 (also vol. xiv, pp. 11 and 36).
34. H. Lambert Lack (**M. G. C. R.**, vol. xiv, pp. 97-8). Scirrhous Carcinoma of Right Vocal Cord. Vol. xiv, p. 95, May, 1907.

VI. THYROID GLAND.

1. R. Lake. Cystic degeneration of the Thyroid Gland in a case of Exophthalmic Goitre. Vol. i, p. 102, May, 1894.
2. W. G. Spencer. Fibrous degeneration of the Thyroid Gland. Vol. ii, p. 24, December, 1894.
3. P. de Santi. Parathyroid Tumour. Vol. vi, p. 104, June, 1899.
4. Dundas Grant. Sarcoma of the Thyroid Gland. Vol. viii, p. 9, November, 1900.

PART B.

SUPPLEMENTARY CATALOGUE
(Non-Reference).

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1. Soft-cell Fibro-angioma from Floor of Vestibule. L. H. Pegler.
2. Cystic Wart from Vestibule. Lambert Lack.
3. Atrophic Rhinitis of Nasal Cavity (early stage). Lambert Lack.
4. Inflammatory Polypoid Growth of Nasal Cavity ("Crundle" Case). Wyatt Wingrave.
5. Granulomatous Growth of Nasal Cavity ("Corinder" Case). Wyatt Wingrave.
6. Inflammatory Growth of Nasal Cavity (with Glands). W. H. Kelson.
7. Simple Mucous Polypus of Nasal Cavity. L. H. Pegler.
8. Mucous Polypus (inflamed). L. H. Pegler.
9. Cystic Polypus of Nasal Cavity. James Donelan.
10. Squamous-cell Carcinoma of Nasal Cavity. Wyatt Wingrave.
11. Squamous-cell Carcinoma of Nasal Cavity. L. H. Pegler.
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22. Decalcified Section of Inferior Turbinate. L. H. Pegler.
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29. Squamous Papilloma of Inferior Turbinal Region. R. Lake.
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 37. Polypoid Granulations from Maxillary Antrum. L. H. Pegler.
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2. Soft-cell Angeio-fibroma. Wyatt Wingrave.
3. Post-nasal Adenoid. L. H. Pegler.

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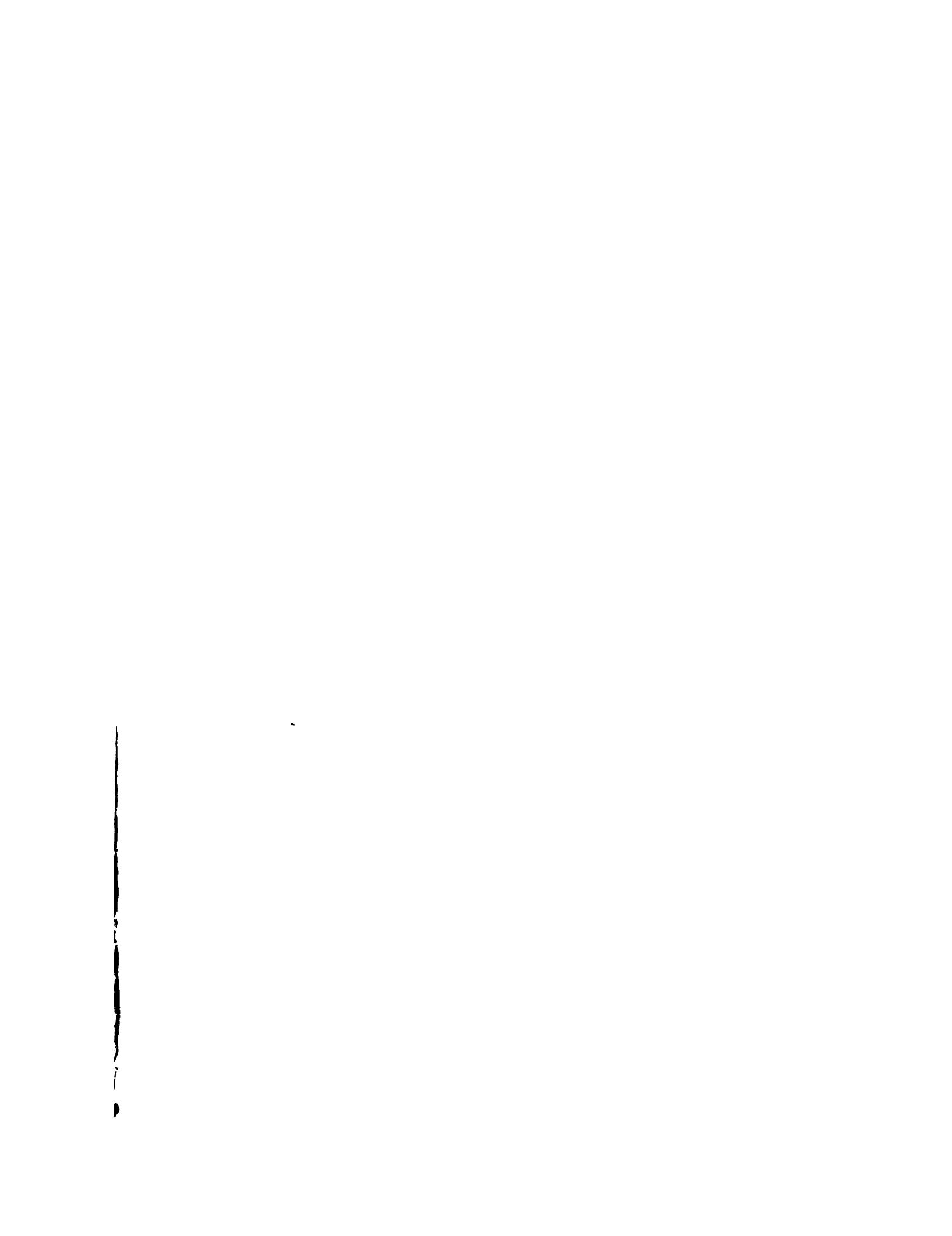
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 - 15—32. *A Series of eighteen Operated Cases of Squamous-cell Carcinoma of the Larynx.* Sir Felix Semon.
 33. Tuberculous Nodule of Vocal Cord ("Gee" Case). R. Lake.
 34. Tuberculous Nodule of Larynx ("Karolyski" Case). R. Lake.
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2. Thyroid Gland in Graves' Disease. R. Lake.
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